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EVALUATION

NURTURING THE MOTHER-CHILD DYAD IN AN URBAN SETTING: FINAL EVALUATION OF THE HATI KAMI PROJECT IN JAKARTA, INDONESIA

DECEMBER 2014

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Kathy Tilford, Independent Consultant, with assistance from the Hati Kami team for certain annexes.

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Kathy Tilford
Lead Evaluator

FINAL EVALUATION OF THE HATI KAMI CHILD SURVIVAL PROJECT

RESULTS OF NURTURING THE MOTHER-CHILD DYAD FROM PREGNANCY THROUGH THE FIRST SIX MONTHS OF LIFE: FINAL EVALUATION OF A FOUR-YEAR URBAN HEALTH PROJECT

December 2014

CSHGP Cooperative Agreement No. AID - OAA - A -10 - 00063

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CONTENTS

ACRONYMS AND TERMS

AMSTL	Active Management of the Third Stage of Labor
BCC	Behavior Change Communication
BFC	Breastfeeding Counseling (refers to the WHO standard 40-hour course)
CFW-UI	Center for Family Welfare Research, University of Indonesia
CHV	Community health volunteer, known as Kader (unpaid)
CQI	Continuous Quality Improvement
CSHGP	Child Survival and Health Grants Program
CU2	Children under two years of age
CU5	Children under five years of age
DIP	Detailed Implementation Plan
EBF	Exclusive Breastfeeding
FGD	Focus Group Discussion
IBCLC	International Board Certified Lactation Consultant
IBI	Indonesian Midwives Association (Ikatan Bidan Indonesia)
IR	Intermediate Result
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
KKA	Kedaung Kali Angke (participating sub-district)
KPC	Knowledge, Practice and Coverage Survey
LAMAT	Local Area Monitoring and Tracking
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MCHN	Maternal and Child Health/Nutrition
MHO	Municipality Health Office (for West Jakarta)
MoH	Ministry of Health
m-PWS	Mobile Area Monitoring and Tracking (Sistem Pemantauan Wilayah Setempat secara Mobil)
MSG	Mothers Support Group
OR	Operations Research
PHC	Public Health Center (Puskesmas)
PHO	Provincial Health Office (for Jakarta Province)
PKK	A civil society organization associated with the Ministry of Home Affairs (Pemberdayaan Kesejahteraan Keluarga)
Posyandu	Health Post (Pos Pelayanan Terpadu)
RW	Community consisting of a cluster of 8 to 19 neighborhoods (Rukun Warga)
SBMR	Standards Based Management and Recognition
SOW	Scope of Work
ToT	Training of Trainers

Mother and child participating in a Mothers Support Group in West Jakarta Municipality

Key Findings:

Achieved both project Objectives, exceeding targets for 11 of 13 Key Program Indicators

Successfully adapted a self-assessment tool (SBMR) to improve performance of private midwives delivering MCH services

Set the stage for sustainability of a number of program effects and initiatives by reinforcing solid partnerships with government and private organizations

Promoted strong community engagement through training, BCC activities and identifying "champions" to promote key messages

Tested an approach for using mobile phones for routine data collection, creating high interest within the Ministry of Health for using mobile technology

Scale up of several interventions already being undertaken by key partners, including the PHO

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Final Evaluation of the Hati Kami Child Survival Project - Executive Summary

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

October 2014

Evaluation Purpose and Evaluation Questions

The overall purpose of this evaluation was to assess the performance of the project at the end of four years of implementation, documenting results and the reasons for these results. This included testing the assumptions underlying the Results Framework, determining program impact, and identifying lessons learned in order to propose recommendations for future programming. The final evaluation process gave an opportunity for the beneficiaries and key stakeholders – the Ministry of Health structures (MoH), the USAID Mission, project staff, local organizations and other partners – to provide input during the qualitative field work and during the dissemination of the preliminary results of the evaluation in-country.

Evaluation questions: To guide the final evaluation, the Scope of Work (SOW) proposed four key evaluation questions:

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the Detailed Implementation Plan (DIP)?
2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?
3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?
4. What are stakeholder (community members, Municipality Health Office) perspectives on the Operations Research (OR) implementation, and how did the OR study affect capacity, practices, and policy?

In addition to these four questions, the evaluation team also examined four Learning Themes proposed for all 2014 CSHGP Final Evaluations: Community Engagement; Service Delivery, Equity and Continuous Quality Improvement; Scale

FINAL EVALUATION EXECUTIVE SUMMARY

Project Background

Hati Kami, an urban health project located in the West Jakarta Municipality of Jakarta Province in Indonesia, is a four-year Innovation Child Survival and Health Grants Project (CSHGP) implemented by Mercy Corps and its public and private sector partners. The project, whose name means "Our hearts", was designed to address high rates maternal and neonatal mortality, increased rates of bottle/formula feeding, and limited growth in exclusive breastfeeding (EBF) rates; it successfully built on the results and lessons learned of Healthy Start, Mercy Corps' previous CSHGP project in Jakarta Province. The overarching goal of the project, implemented from September 2010 through September 2014, was to "promote, support, and protect the mother-child dyad for a healthy start among Jakarta's poor residents" according to the project proposal. To do this, activities were designed to achieve two interrelated Objectives: 1) Improved maternal child care and nutrition **practices** of mothers from pregnancy through the first 6 months of life and 2) Improved quality of maternal, newborn and infant **services**.

Key interventions included: establishing Mothers Support Groups (MSGs) for reaching mothers with critical information on breastfeeding and maternal and newborn care; integrating counseling on maternal-infant health and nutrition into the 7+ contacts in maternal-newborn care[1]; scaling up WHO's 40-hour Breastfeeding Counseling (BFC) training; implementing a targeted communication strategy; adapting the Standards Based Management and Recognition (SBMR) approach for private midwives; supporting the Municipality Health Office (MHO) and local branch of the Indonesian Midwives Association (Ikatan Bidan Indonesia, IBI) to train providers on the Kangaroo Mother Care method; and replicating the 10 steps to successful breastfeeding model of the previous Healthy Start project.

The **Operations Research (OR) component** was designed to address current shortcomings in the existing implementation of the MoH maternal and child health Local Area Monitoring and Tracking (LAMAT) system. The OR, hereinafter referred to as m-PWS (short for Mobile Area Monitoring and Tracking in Indonesia) was conducted in partnership with the University of Indonesia's Center for Family Welfare Research (CFW-UI). With m-PWS, Hati Kami and CFW-UI investigated the use of mobile phone technology to improve the quality of MCH-LAMAT data with a cost-effective, efficient and user-friendly mobile-based electronic health record system. The m-PWS tool was tested throughout the data process (from data collection to data analysis) to see if it can be used for inclusive and participatory data monitoring and tracking purposes.

Evaluation Design and Methods

The evaluation team was responsible for collecting and analyzing qualitative primary data using focus group discussions (FGDs), Key Informant Interviews (KIIs) and observation. The team also reviewed and analyzed secondary quantitative data from baseline and endline surveys and assessments. In addition to the qualitative and quantitative data, the lead evaluator also completed a thorough document review including the original proposal narrative, the DIP, annual reports, reports to donors, strategies such as the Behavior Change Communication (BCC) strategy, midterm assessments, and reports sent by external visitors. She also used observation as a technique, especially of interactions among the Hati Kami team, partners and beneficiaries.

At the end of the field work the evaluation team met in a one-day workshop to analyze results, draw preliminary conclusions and propose recommendations. Following the workshop, the lead

[1] 7+ refers to 7 (or more) contacts with a breastfeeding counselor when a woman is: 28 weeks pregnant; 36 weeks pregnant; in labor and delivery; after delivery and still admitted; 7th day post-delivery; 14th day post-delivery; and 39 days post-delivery. The + includes additional contact with counselors after the first 40 days of the baby's life.

evaluator organized a series of shorter meetings with the Hati Kami team for additional analysis. The lead evaluator triangulated findings from the document review, her observations of interpersonal dynamics and the quantitative data from the endline surveys and assessments. Additional input was provided by the stakeholders when the preliminary results were shared.

Findings and Conclusions

For Objective 1, targets were exceeded for six of the seven Key Program Indicators (all six statistically significant), demonstrating that Intermediate Result 1(IR1) (Increased knowledge and skills of mothers) was accomplished, largely as a result of the MSG approach and the Behavior Change Communication (BCC) strategy. Two of the more notable achievements for improvements in maternal/child care and nutrition practices were 1) the increase in EBF by almost 20 points, from 23.4% to 42.7% and 2) the increase in the percentage of children who did not receive pre-lacteal feeds, from 47% to 76.4%. These changes in practices are traditionally among the more difficult to achieve where Infant and Young Child Feeding (IYCF) are concerned. The one target that was not met was for "Timely Initiation of Breastfeeding".

Of the six Key Program Indicators for Objective 2, five exceeded the target with statistical significance. What is especially encouraging is that the **quality of health services** for antenatal, delivery and postpartum care all improved, including Active Management of Third Stage Labor (AMTSL). As for the two indicators measuring access to counseling, the percentage of mothers of children under 2 (CU2) who reported receiving counseling during their last pregnancy nearly doubled (from 40% to 79.7%), but there was a disappointing decrease in the percentage of pregnant women who reported receiving counseling during their current pregnancy; this raises concerns about the extent to which providers, especially midwives, are counseling pregnant women.

In evaluating the major activities undertaken by Hati Kami, the most problematic has been the OR. Of the six research questions in the OR design, the first three (accuracy of reporting, timeliness of reports and level of participation) could not be answered due to either a lack of data for certain periods or incomplete data. Sufficient data was available to answer Question 4 – use of maternal and child health (MCH) data for local planning. Utilization was not higher in the m-PWS area for internal planning but was higher in the m-PWS area for the quarterly planning sessions between the Rawa Buaya Public Health Center (PHC) and the community. The last two research questions concerned barriers and enabling factors for the use of the m-PWS and there was useful data generated for these questions. In spite of the problems encountered, the OR initiative has resulted in a number of **positive benefits**. By demonstrating the potential of mobile technology, it raised the awareness of stakeholders and generated widespread interest in replicating mobile approaches for monitoring and tracking.

After reviewing and discussing the quantitative data and corroborating evidence from the qualitative evaluation and a detailed document review, the evaluation team concluded that **Hati Kami has been successful, achieving both of its Objectives and most of the intended results**. In addition, the project team has enhanced the original project proposal design by achieving measurable results with the addition of innovative activities such as adapting SBMR for private midwives and providing financial advocacy training.

The Hati Kami Project in West Jakarta, Indonesia is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Hati Kami Project is managed by Mercy Corps under Cooperative Agreement No. AID - OAA - A -10 – 00063. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about the Hati Kami Project, visit: www.mercycorps.org

EVALUATION PURPOSE AND EVALUATION QUESTIONS

Purpose: The overall purpose of this evaluation was to assess the performance of the project at the end of four years of implementation, documenting results and the reasons for these results. This included testing the assumptions underlying the Results Framework, determining program impact, and identifying lessons learned in order to propose recommendations for future programming. The final evaluation process gave an opportunity for the beneficiaries and key stakeholders – the Municipality Health Office (MHO), the USAID Mission, project staff, local organizations and other partners – to provide input during the qualitative field work and during the dissemination of the preliminary results of the evaluation in-country.

Findings from this evaluation will be disseminated within Mercy Corps and to: the principal stakeholders including organizations and agencies that implemented the project with Mercy Corps; the USAID Mission in Indonesia; the CSHGP office; and other organizations that have expressed an interest in the project. It will also be available to the public once posted on the Maternal and Child Health Integrated Program (MCHIP) and Development Clearinghouse Web sites. It is anticipated that the report will be used within Indonesia to inform forward planning for scaling up project interventions, especially in Jakarta Province; other NGOs and organizations may find it useful for designing similar projects promoting improved maternal care and infant health, especially for breastfeeding and prenatal care initiatives.

A lead evaluator was hired with project funds to guide the evaluation; she had had no previous connection with Mercy Corps/Indonesia or with the Hati Kami project. USAID approved the evaluator and both USAID and EnCompass reviewed the draft Scope of Work (SOW). The lead evaluator submitted the draft report simultaneously to EnCompass and to Mercy Corps Headquarters.

Evaluation questions: To guide the final evaluation, the SOW proposed four key evaluation questions, each of which had a subset of related questions (See Annex VIII for the complete SOW):

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the Detailed Implementation Plan (DIP)?

2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?

4. What are stakeholder (community members, Municipality Health Office) perspectives on the Operations Research (OR) implementation, and how did the OR study affect capacity, practices, and policy?

In addition to these four questions, the evaluation team also examined four Learning Themes proposed for all 2014 CSHGP Final Evaluations: Community Engagement; Service Delivery, Equity and Continuous Quality Improvement; Scale Up and Sustainability; and Learning and Adaption, including Operations Research. For Service Delivery, Equity and Continuous Quality Improvement (CQI), the team did not make a special effort to look at Equity as access to services is not a major issue in the project area.

PROJECT BACKGROUND

Hati Kami, an urban health project located in the West Jakarta Municipality of Jakarta Province in Indonesia, is a four-year Innovation Child Survival and Health Grants Project implemented by Mercy Corps and its public and private sector partners. It was designed to address a number of maternal/child health issues that the MoH considers high priorities, including:

- Increased rates of bottle/formula feeding and limited growth in exclusive breastfeeding (EBF) rates
- Unacceptably high rate of maternal mortality (The lifetime risk of maternal mortality in Indonesia is one in 150 compared with one in 400 in developed countries[2].)
- Lack of significant decline in the neonatal mortality rate (The 2007 Indonesia Demographic and Health Survey reported 19/100,000 live births with almost 80% of deaths occurring in the first week of life.)
- With over 50% of Indonesia's population living in urban areas, it is also a priority of the MoH to address the particular health issues among the urban poor that are associated with overcrowding, poor sanitation conditions and lack of the social safety nets one finds in rural communities.[3]

The project, implemented from September 2010 through September 2014, was designed to improve mothers' practices for their own health when pregnant and the health of their child and to improve the quality of services available for pregnant women and newborns. It successfully built on the results and lessons learned of Healthy Start, Mercy Corps' previous CSHGP project in Jakarta Province. The overarching goal of the project was to "promote, support, and protect the mother-child dyad for a healthy start among Jakarta's poor residents" according to the project proposal. To do this, activities were designed to achieve two interrelated Objectives: 1) Improved maternal child care and nutrition **practices** of mothers from pregnancy through the first 6 months of life and 2) Improved quality of maternal, newborn and infant **services**.

Mercy Corps and the Provincial Health Office (PHO) jointly selected the **project location**, West Jakarta Municipality, for three reasons: its health indicators were among the poorest in Jakarta Province; the Municipality is an important point of entry and exit for new migrants to the city; and Mercy Corps had well-established relationships with the local government and with the PHO, MHO and other actors in the health sector. West Jakarta Municipality is composed of eight Districts and Hati Kami works in the Cengkareng and Kalideres Districts. Based on health statistics, especially anthropometric data, and population density, the West Jakarta MHO and Mercy Corps identified a total of eight sub-districts (out of 56) for project implementation (all six sub-districts in Cengkareng and two sub-districts in Kalideres). The following table shows the levels at which Hati Kami works with the MoH and administrative officials:

[2] The Lancet, Volume 360, Issue 9858
[3] UNICEF Indonesia Issue Brief October 2012

Table 1. Administration and MoH Structures

Administrative Division	MoH Structure
Jakarta Province	Provincial Health Office (PHO); reports to Governor's office
West Jakarta Municipality	Municipality Health Office (MHO); reports to Mayor's office
2 Districts: Cengkareng and Kalideres	2 District Public Health Centers (PHC or *Puskesmas*); administrative officials and community leaders
8 Sub-districts[4]	14 Sub-district PHCs; administrative officials and community leaders; community health volunteers (Kaders)
RW (*Rukun Warga*, a cluster of 8-19 neighborhoods)	*Posyandu* (Health Post), with support from community health volunteers, administrative officials and community leaders

Over the four years of the project, activities were designed to benefit 221,221 women of reproductive age (WRA) and 65,845 children under 5 (CU5). The beneficiary breakdown by District is provided in the table below. Note that these figures are higher than those reported in the DIP and other project documents as this new table is based on updated 2013 figures provided by the Indonesian government.

Table 2. Beneficiary Population

Beneficiary Population	Cengkareng (6 sub-districts)	Kalideres (2 sub-districts)	Total
Total Population in project area	577,154	160,253	737,407
Total Children 0-59 months	50,275	15,570	65,845
Children 0-11 months	10,695	3,399	14,094
Children 12-23 months	10,177	3,201	13,378
Children 24-59 months	29,403	8,970	38,373
Women of Reproductive Age (WRA)	173,146	48,075	221,221
Total WRA and CU5	223,421	63,645	287,066

(*Calculations based on latest population figures from Sub-district Government Offices for 2013*)

The following short form of the **Results Framework** shows how the two Objectives would be reached. (For a more detailed Results Framework, see Annex XIX - A.)

Objective 1. Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life
IR1. Increased knowledge and skills of mothers on breastfeeding and essential maternal-newborn care
IR2. Increased access to social support for mothers on breastfeeding and key maternal-newborn care

Objective 2. Improved quality of maternal, newborn and infant services
IR3. Increased skills and compliance of the health providers on MCHN counseling, AMTSL, essential newborn care and the baby friendly protocols.
IR4. Increased use of MCH data for decision making and advocacy.

Key interventions included: establishing Mothers Support Groups (MSGs) for reaching mothers with critical information on breastfeeding and maternal and newborn care; training Motivators to facilitate the MSGs and to conduct outreach; providing Mentors to support the

[4] Duri Kosambi, Rawa Buaya, Kedaung Kaliangke, Kapuk, Cengkareng Timur and Barat in Cengkareng District; Tegal Alur and Kamal in Kalideres District

Motivators; integrating counseling on maternal-infant health and nutrition into the 7 contacts+[5] in maternal-newborn care; scaling up WHO's 40-hour Breastfeeding Counseling (BFC) training; implementing a targeted communication strategy; adapting the Standards Based Management and Recognition (SBMR) approach for private midwives; supporting the MHO and local branch of the Indonesian Midwives Association (IBI) to train providers on the Kangaroo Mother Care method; and replicating the 10 steps to successful breastfeeding model of the previous Healthy Start project.

The **Operations Research** (**OR) component** was designed to address current shortcomings in the existing implementation of the MoH's maternal and child health Local Area Monitoring and Tracking (LAMAT) system. The OR, hereinafter referred to as m-PWS (short for Mobile Area Monitoring and Tracking in Indonesia) was conducted in partnership with the University of Indonesia's Center for Family Welfare Research (CFW-UI). Many of the shortcomings of the current system have roots in the manual data recording and reporting of LAMAT data (i.e. using paper-based health records). Although the Ministry has provided electronic database software for health offices to report data online to the national level since 2008, the data collection at the sub-district level and below remains heavily paper-based, irregular, and of sub-standard fashion. Recording and maintaining physical health records is time consuming and labor intensive.

With m-PWS, Hati Kami and CFW-UI investigated the use of mobile phone technology to improve the quality of MCH-LAMAT data with a cost-effective, efficient and user-friendly mobile-based electronic health record system. The two objectives for the OR were 1) to evaluate whether the m-PWS system can improve collection and use of quality data to inform local health planning and resource allocation and 2) to document enabling factors and barriers to the scale-up of the m-PWS system. The m-PWS tool was tested throughout the data process (from data collection to data analysis) to see if it can be used for inclusive and participatory data monitoring and tracking purposes.

The OR was conducted in two of the eight sub-districts in West Jakarta where the Hati Kami project was located. The two sub-districts have similar estimated population totals (based on government statistics), and each has only one Public Health Center (PHC) in charge of all health reporting. Using a 'flip of a coin' Kedaung Kaliangke (KKA) sub-district was originally randomly selected as the intervention area where m-PWS would be implemented and Rawa Buaya (RB) was originally selected as the control area where the paper-based LAMAT system would continue to be implemented. After the baseline research was completed, the OR team found there was only one private midwife practicing in Kedaung Kaliangke whereas Rawa Buaya had a number of private midwives. Since the OR required greater numbers of private midwives to obtain useful feedback for ongoing m-PWS development, it was decided in Year 3 in consultation with the OR advisory board, to switch these two areas. In both the 'intervention' area (Rawa Buaya) and the 'control' area (KKA), evaluative research consisting of quantitative and qualitative assessments was carried out before and 12 months after the introduction of m-PWS in the 'intervention' area.

One of the defining characteristics of Hati Kami is the extent to which it has been implemented from the beginning with **partners in both the public and private sectors**. The MoH is highly

[5] 7+ refers to 7 (or more) contacts with a breastfeeding counselor when a woman is: 28 weeks pregnant; 36 weeks pregnant; in labor and delivery; after delivery and still admitted; 7th day post-delivery; 14th day post-delivery; and 39 days post-delivery. The + includes additional contact with counselors after the first 40 days of the baby's life.

decentralized in Indonesia and the project worked most closely with the MHO, which is under the supervision of the West Jakarta Mayor's office; the Provincial Health Office or PHO, which reports to the Governor's office; 16 PHCs; and the Posyandu. In addition to administrative authorities, community leaders and the various levels of the MoH, Hati Kami designed and implemented activities with four other principal groups: private midwives; the Indonesian Midwives Association (IBI); PKK, a civil society organized associated with the Ministry of Home Affairs and consisting mainly of women volunteers; and the Indonesian Moslem Leaders Assembly (West Jakarta branch). The Hati Kami team also collaborated with another USAID-funded project, MCHIP, for the adaptation of the SBMR tool developed by MCHIP.

The Hati Kami project directly supports the priorities outlined in the 2009-2014 **USAID Mission Strategy** for the health sector: improving the quality of services delivered by skilled birth attendants; reinforcing the institutional capacity of IBI; strengthening civil society organizations for improved local efforts to lower maternal and neonatal mortality; collaboration with private health care providers; and a focus on initiatives in urban areas. In addition, the USAID/Indonesia health team expressed great interest in the use of mobile technology for data collection during the final evaluation dissemination meeting September 19, 2014 and made arrangements to observe this aspect of the project the following week.

EVALUATION METHODS AND LIMITATIONS

This section primarily describes the qualitative methods and analysis used during the two-week qualitative evaluation. A brief overview is also provided for the quantitative data used for the final evaluation. This includes the baseline/endline surveys and assessments and the OR data.

The Qualitative Evaluation

The **evaluation team** conducted the qualitative evaluation during a two-week period in September 2014. The team was composed of an external consultant who served as lead evaluator; members of the Hati Kami project team; and four external partners representing the West Jakarta branch of IBI, the MHO, the Kalideres District, and the Cengkareng District. (See Annex XIV for a description of the team.) All four external partners were health professionals and had been involved in various aspects of Hati Kami. In addition to the core team, a second external consultant was hired part-time to conduct some of the Key Informant Interviews (KIIs) with private midwives and PHC staff.

The evaluation team was responsible for collecting and analyzing qualitative primary data using focus group discussions (FGDs), KIIs and observation. The team also reviewed and analyzed quantitative data from baseline and endline surveys and assessments and the OR final report. In addition to the qualitative and quantitative data, the lead evaluator also completed a thorough document review including the original proposal narrative, the DIP, annual reports, reports to donors, strategies such as the BCC strategy, midterm assessments, and reports sent by external visitors. She also used observation as a technique, especially of interactions among the Hati Kami team, partners and beneficiaries.

Qualitative Data Collection: Prior to her arrival in country, the lead evaluator worked with the Hati Kami team to identify potential individuals and groups to interview. Because Hati Kami works through existing structures and organizations and because it has substantial community involvement, the initial list of people to interview was too ambitious for the two-week time period. In consultation with the Health and Nutrition Program Manager and the M&E Specialist, the lead evaluator made the decision to include the following individuals and groups in the

qualitative data collection:

- For FGDs: MSG participants; MSG Motivators; community leaders and Community Health Volunteers (CHVs) involved in m-PWS
- For KIIs: Private midwives; MSG Mentors (primarily PKK members); PHC staff; all Hati Kami staff; MHO; IBI; PKK; the Mercy Corps/Indonesia Country Director; the Mercy Corps/Indonesia Finance Director; the Director of Public Health at Mercy Corps headquarters; and a consultant who had provided substantial technical assistance

Draft **data collection instruments** were developed by the lead evaluator prior to her arrival in country and then revised and translated during a one-day workshop with the Hati Kami team. Each instrument included a set of generic questions to allow for cross-comparison of responses from different groups and individuals. The majority of these generic questions focused on the four Learning Themes: Community Engagement; Service Delivery and CQI; Scale up and Sustainability; and Learning and Adaption. The revised instruments were then shared with the entire evaluation team during a one-day workshop and members of the team had the opportunity to practice using them via role plays. Given time constraints and the number of instruments, it was not possible to conduct a field test but following the first day of field work, the team met to discuss how well the instruments worked and modified both FGD guides to eliminate repetitious questions and questions that yielded little useful information.

The FGDs were conducted by two-person teams, usually a Hati Kami team member paired with one of the external partners. In some cases, however, the interview team was composed of two Hati Kami team members as there were only four external partners available. The lead evaluator conducted all the KIIs with Mercy Corps personnel, including the project staff; she also conducted approximately half of the other KIIs. A part-time consultant conducted some of the KIIs with private midwives and PHC staff. The lead evaluator and the part-time external consultant also observed several of the FGDs with Motivators and MSG participants.

In **selecting sites and participants** for the qualitative data collection, an important criterion was to ensure that all eight sub-districts in the project area were represented. To this end, one FGD with Motivators and one FGD with MSG participants were conducted in each sub-district for a total of 16 FGDs for these two groups. Since these FGDs needed to be scheduled prior to the lead evaluator's arrival in country, the Hati Kami team relied on Mentors, Motivators and PHC staff to ensure that each FGD had 10-12 members.

In choosing the six PHCs for KIIs, it was important to include the two PHCs involved in the OR: Rawa Buaya, the intervention site, and KKA, the control site. For the remaining four, the Hati Kami team prepared a list of potential PHCs and the lead evaluator randomly selected two from each district. The same system was used to select the private midwives, with the lead evaluator randomly selecting four from a list. As for the Mentors who provide support to the MSG Motivators, priority was given to Mentors who were PKK members since this civil society organization plays an important role in the project.

To facilitate the **analysis of the qualitative data**, team members took time at the end of each day of field work to record responses in spreadsheets. At the end of the field work the evaluation team met in a one-day workshop to analyze results, draw preliminary conclusions and propose recommendations. Following the workshop, the lead evaluator organized a series of shorter meetings with the Hati Kami team for additional analysis. The lead evaluator triangulated findings from: the document reviews, her observations of interpersonal dynamics

and the quantitative data from the endline surveys and assessments; and the OR final report. Additional input was provided by the stakeholders when the preliminary results were shared.

Baseline/endline Quantitative Data
Especially useful for triangulation was the data from the **endline quantitative surveys and assessments** conducted from June through August 2014. For Objective 1 endline data was collected for two population-based surveys: a repeat of the baseline **Knowledge, Practice and Coverage** (**KPC) Survey** with mothers of CU2 and a repeat of the baseline **Maternal Nutrition Survey** with pregnant women. (See Annex VI for detailed report.). The endline instruments omitted some questions used in the baseline that were no longer applicable (e.g., planned activities that were not implemented such as the use of SMS for BCC).

The cluster sampling method was applied for both the KPC and the Maternal Nutrition surveys, with clusters defined as the community neighborhood unit (RW). For the KPC Survey the baseline sample was 300 mothers and the endline sample was 330 mothers[6]. For the Maternal Nutrition Survey 780 pregnant women were interviewed during the baseline survey and 575 during the endline exercise. Enumerators used Smartphones equipped with DataDyne software and once the data had been checked and verified by supervisors, the enumerators sent the data to the DataDyne server. Analysis was conducted using SPSS 17 Trial Version.

For Objective 2, the evaluation team used the results of two endline assessments, which repeated the baseline assessments: an assessment of SBMR with 25 private midwives and an assessment of baby-friendly protocols at 20 health facilities in the project area. (See Annex VI for the report of the two endline assessments for Objective 2.)

OR Data
In comparing m-PWS against a manual, paper-based system, the OR examined six research questions, each of which had its own indicators:

1. Is the discrepancy of MCH indicators between the LAMAT report and the population-based survey significantly smaller in the m-PWS area than in the paper-based LAMAT area? (accuracy)
2. Does the PHC in m-PWS area submit timely LAMAT reports more frequently than the PHC in paper-based LAMAT area? (timeliness)
3. Is the participation in reporting among public and private health providers and community health volunteers (kader) higher in the m-PWS area than in the paper-based LAMAT area?
4. Is the use of data for local planning higher in the m-PWS area than in paper-based LAMAT area?
5. What are the enablers and barriers for health providers and community health volunteers (kader) regarding implementation of the m-PWS system? (considering cost factors, ease of use, feedback, time constraints/ efficiency)
6. What does the government perceive as the barriers and enabling factors for scaling-up the m-PWS system?

Data collection and analysis methods were tailored to each research question. For example, to measure *timeliness of reporting*, the research partner conducted baseline, midterm and endline document reviews at the PHCs. To assess *enabling factors and barriers* to scaling up the m-

[6] A 10% reserve was added to allow for any errors in data collection.

PWS system, the methodology was different: the research partner conducted in-depth interviews with PCH heads and private health care providers. (For a more detailed description of data collection methods and analysis for each research question, see Annex XV.)

Data Quality and Use

In terms of data available to the evaluation team, the evaluation team did not use data from the MoH or other government agencies as it is not always reliable. Even obtaining current realistic population figures for the two Districts was problematic. The team relied on the qualitative data collected during the September 2014 fieldwork; the baseline and endline surveys and assessments for Objectives 1 and 2; and the OR data.

Possible limitations of the qualitative evaluation methodology include the following:

1. Having Hati Kami team members on the evaluation team: This could introduce bias into the data collection. To mitigate this possibility, Hati Kami team members did not conduct interviews in the areas in which they worked and when possible, they were paired with an external partner. Almost all the KIIs were conducted by the external consultants except for three of the KIIs with Mentors.

2. Time constraints: Conducting the entire qualitative evaluation, including preparatory workshops and dissemination meetings, in two weeks was challenging. One result was that not all groups could be interviewed. If more time had been available, it would have been useful to interview religious leaders, other members of the organizational partners, more government officials and additional community leaders. Even for the groups selected, it would have been helpful to have more interviews, especially with private midwives and the key organizational partners. The time constraint also negated the possibility of using recorders and transcribing the interviews later.

3. Interpreters: Both external consultants relied on interpreters for a number of their interviews. Although the interpreters were competent, it is likely that some key information was missed.

4. Choice of sites and participants: Although a certain amount of randomness was introduced into the selection of sites and participants, the initial lists were prepared by project staff. This was both a factor of time available and the need to set up the FGDs and KIIs in advance.

The **quality of the quantitative data** from the baseline and endline surveys and assessments was good and the M&E Specialist promptly provided explanations and additional data upon request. However, three of the 13 Key Program Indicators needed to be recalculated during the final evaluation. (See Table 3 on the following page for a list of the 13 Key Program Indicators used to evaluate the project.) For the EBF indicator, a child who was exclusively breastfed in the past 24 hours but who had had a prelacteal feed was not counted as exclusively breastfed. The baseline and endline values were recalculated using the Rapid CATCH definition[7]. The other two Indicators that were revised were the Counseling Access for Mothers and the Counseling Access during Pregnancy Indicators. Both indicators state "…received counseling on breastfeeding *or* maternal and infant care messages". However, in the baseline survey respondents had to answer all messages for both breastfeeding *and* maternal and infant care in order to be counted. In recalculating the values, respondents who answered either

[7] % children 0-5 months who were exclusively breastfed during the last 24 hours

breastfeeding or maternal and infant care messages (or both) were counted.

For the evaluation team, the principal problem in terms of data quality was the OR data. As noted earlier, data for three of the six research questions (accuracy of reporting, timeliness of reports and level of participation) was either missing altogether for certain periods or incomplete. However, the team did find quite useful the OR data on enabling factors and barriers to scaling up m-PWS.

Attribution

Two factors facilitated attribution of results to the project: the project design and the project documentation. First, the clarity of the project design, the logic connecting the two Objectives and the four IRs and the fact that the design, including the number of activities, was not too ambitious made it easier to determine to what extent the project activities and strategies contributed to the results. Second, good documentation, especially for Years 1-3, provided not only descriptions of what activities were implemented but also the constraints encountered and how the project team overcame problems and setbacks. A third factor that facilitated attribution is the fact that no other organizations are carrying out similar activities in the project area.

Table 3. 13 Key Program Indicators
(* = statistically significant. See Annex XIX - B for confidence intervals.)
(NA = Statistical significance not applicable

INDICATOR	BASELINE	TARGET	ENDLINE
Objective 1: Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life			
1. Timely initiation of breastfeeding: % children 0-23 months who were put on the breast within 1 hour after delivery	62.3%	72%	64.8%
2. Early initiation of breastfeeding: % children 0-23 months who were put on the mother's breast or tummy's skin right after birth for at least 1 hour or until it stopped suckling	23.3%	33%	40.6%*
3. Exclusive breastfeeding: % children 0-5 months who were exclusively breastfed during the last 24 hours	23.4%	38%	42.7%*
4. No pre-lacteal feeds: % children age 0-23 months who did not receive pre-lacteal feeds	47%	55%	76.4%*
5. Having more carbohydrate in pregnancy: % pregnant women who reported having increased portion of staple food during pregnancy	23.7%	25%	64.9%*
6. Iron supplement in pregnancy: % pregnant women who reported taking an iron supplement yesterday	56.4%	60%	67.3%*
7. Folic acid supplement in pregnancy: % pregnant women who reported taking folic acid tablet yesterday	62.1%	65%	81.4%*
Objective 2: Improved quality of maternal, newborn and infant services			
1. Quality antenatal care: % health service providers' compliance in giving standard antenatal care	87%	89%	92.4% (NA)
2. Compliance to standard post-partum and post-natal care: % health service providers' compliance in giving standard post-partum and post-natal care	92.5%	94%	98.3% (NA)
3. Compliance to standard normal delivery and newborn care: % health service providers' compliance in giving standard normal delivery and newborn care	88%	90%	96.8% (NA)
4. Active management of the third stage of labor (AMTSL): % mothers of children age 0-23 months who received AMTSL after the birth of her youngest child	30%	35%	43.6%*
5. Counseling access for mothers: % mothers of children age 0-23 months who received counseling on breastfeeding or maternal and infant care messages	40%	50%	79.7%*
6. Counseling access for pregnant women: % pregnant women who received counseling on breastfeeding or key maternal and infant care messages	71.5%	81.5%	58.1%*

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This section includes discussions of the Evaluation Questions from the SOW and the Learning Themes proposed for all 2014 CSHGP Final Evaluations. Throughout this section references are made to the 13 Key Program Indicators. These are shown in Table 3 on the preceding page and excerpts are included under the "Outcomes" column in Tables 4 and 5. The complete table with confidence intervals for these Key Program Indicators can be found in Annex XIX - B.

FINDINGS

The Findings section is organized into two parts, one for each Objective. Each part includes a Summary Table of the inputs, activities and outputs that contributed to the outcomes for the Objective.

Project Objective 1: Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life

Table 4. Summary of Inputs, Activities and Outputs that Contributed to Key Outcomes for Objective 1

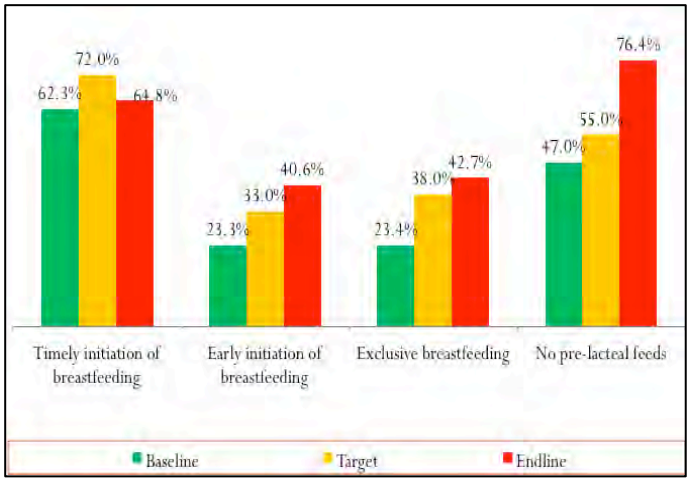
Project Inputs	Activities	Outputs	Outcomes
IR 1. Increased knowledge and skills of mothers on breastfeeding and key maternal-newborn care			**Key Program Indicators**
MSG Master Trainers MSG Motivators and Mentors IEC materials and job aids Cost-share funding from Jakarta PHO,Give2Asia & Johnson & Johnson Indonesia Consultant (IYCF Counseling Master Trainer) IYCF Counseling training kit Course Directors and Senior Facilitators WHO 40 hours BFC training kit Episurveyor/Magpi platform for monitoring Breastfeeding[e]Education by Health[e]Foundation	MSG Mentors training MSG Motivators training Monitoring and evaluation IYCF Counseling training and ToT using UNICEF's module Breastfeeding Counseling Pilot of Blended Learning of Breastfeeding Counseling Course ToT – IYCF Counseling IYCF training for community counselors/volunteers	6 MSG ToTs conducted 96 trained MSG Mentors for West Jakarta 36 trained MSG Mentors for Jakarta Province 512 trained MSG Motivators for 8 sub-districts 94 RW with functioning MSGs 97 functioning MSGs in 94 RWs conduct meeting at least once/month 17 female community volunteers trained and given counseling kit on IYCF 16 MSG M&E meetings at sub-district level (9 were cost-shared) 6 Breastfeeding Counseling Courses conducted 63 private midwives certified as Breastfeeding Counselors with 40-hour course. 27 private midwives in West Jakarta certified as Breastfeeding Counselors via the Blended Learning Course	1.Increase in percentage of children 0-23 months who were put on the mother's breast or abdomen's skin right after birth for at least 1 hour or until it stopped suckling (from 23.3% to 40.6%). 2. Increase in percentage children 0-5 months who were exclusively breastfed during the last 24 hours (from 23.4% to 42.7%). 3. Increase in percentage of children 0-23 months who did not receive pre-lacteal feeds (from 47% to 76.4%). 4. Increase in percentage of pregnant women who reported having increased portion of staple food during pregnancy (from 23.7% to 64.9%) 5. Increase in percentage of pregnant women who reported taking an iron supplement in the last 24 hours (from 56.4% to 67.3%)

Project Inputs	Activities	Outputs	Outcomes
		20 IYCF counseling trainers	6. Increase in percentage of pregnant women who reported taking folic acid tablet in the last 24 hours (from 62.1% to 81.4%) 7. No significant increase in percentage of children 0-23 months who were put on the breast within 1 hour after delivery (from 62.3% to 64.8%)
IR 2. Increased access to social support for mothers on breastfeeding and key maternal-newborn care			
BCC Consultant Mercy Corps Technical Backstop (consultant) Hati Kami: all staff Mercy Corp Indonesia Senior Communication Officer Trainers – Financial Literacy Cash contribution from Prudential USAID: A Toolkit for Religious Leaders Breastfeeding expert-Keynote speaker at Indonesian Moslem Leaders Assembly – West Jakarta branch West Jakarta Mayor's Office staff	Doer Non-Doer research conducted Team retreat & in-house workshop for BCC ToT for Financial Literacy trainings– bridging onward discussion on savings from breastfeeding at the community level Production, launching, and distribution of "MCH from Islam Perspective" set of materials for religious leaders in West Jakarta.	24 banners, 48 posters and 15 Information Boards produced and placed at PHCs and private midwives' offices 2 ToT conducted; 30 people (Hati Kami partners and Hati Kami staff) trained as Financial Literacy Trainers 1,998 people from 65 RW in Hati Kami project area trained in Household Financial Literacy Muslim Khutbah Guide, Flyers, and Pocket Book disseminated to religious leaders and public figures	

To what extent did the project accomplish and/or contribute to the results stated in the DIP for Objective 1?

For Objective 1 (Improved maternal child care and nutrition practices of mothers), targets were exceeded for six of the seven Key Program Indicators (all six statistically significant), demonstrating that IR1 (Increased knowledge and skills of mothers) was accomplished, largely as a result of the MSG approach and the BCC strategy. Two of the more notable achievements for improvements in maternal/child care and nutrition practices were 1) the increase in EBF by almost 20 points, from 23.4% to 42.7% and 2) the increase in the percentage of children who did not receive pre-lacteal feeds, from 47% to 76.4%. These changes in practices are traditionally among the more difficult to achieve where Infant and Young Child Feeding (IYCF) are concerned. The one target that was not met for this Objective was for "Timely Initiation of Breastfeeding". Although the result was not statistically significant, it seems that little progress was made for this practice with the endline result being 64.8% compared to a baseline of 62.3%.

Graph 1. Selected results for Objective 1: Infant feeding



To achieve Objective 1, Hati Kami used a variety of strategies for IR1 and IR2, focusing especially on social and behavior change strategies and strategies to enhance the enabling environment. The **cornerstone strategy is the MSG approach**. Building on the previous Healthy Start project, Hati Kami adapted this approach (e.g., adding an IYCF component) and succeeded in establishing 97 functioning MSGs in 94 RWs (neighborhoods). To lead the MSGs, the project trained close to 600 female Motivators drawn from the RWs. The Motivators are in turn supported by Mentors who are volunteers from the PHCs, from IBI and especially from PKK, which is well-established as a civil society organization in the project area.

During the qualitative field work, the evaluation team learned that the MSG meetings not only increase the knowledge of the pregnant women and mothers who participate, leading to changes in practices, but also provide social support for them. This is especially important in an urban environment with a fluid population where new arrivals often lack the critical support of friends and family. Participants interviewed during the FGDs cited making new friends and having Motivators to go to with questions as advantages of the MSGs. Both the document review and the qualitative results indicated that there is some turnover among the Motivators for different reasons: they gain full-time employment, move away, lack motivation or are too busy with other activities.

One of the intended results of Objective 1 was to find ways to help stakeholders ***scale up*** the MSGs throughout West Jakarta. In addition to giving presentations and advocating for MSGs at health and nutrition fora throughout Jakarta Province, the Hati Kami team developed a set of manuals providing step-by-step instructions and comprehensive tools for those wishing to establish MSGs. In her KII, the Public Health Director for West Jakarta confirmed her desire to replicate MSGs throughout the Municipality.

Although the MSG approach was by and large successful in terms of promoting better practices and providing social support to pregnant women and mothers of young children (based on results from the endline surveys and assessments and the qualitative fieldwork), it could be improved as it is not reaching as many women as anticipated (less than 15% of eligible women participate according to the endline survey results).

Results from the KPC Endline Survey, some of which are shown below in Graphs 1 and 2, were corroborated during the FGDs with MSG participants who cited the key messages they had retained from attending MSG meetings and from other contacts with Motivators, private midwives and PHC staff. The MSG Motivators themselves also consistently cited breastfeeding messages and better nutrition for pregnant women as topics they focus on. The evaluation team also observed high visibility for Hati Kami's key messages via items such as posters, tote bags, and stationery.

BCC was important for the successful implementation of both Objective 1 and Objective 2. Although the definitive **BCC strategy** was not developed until midway through the four-year project cycle, Mercy Corps did devote additional resources to ensuring that it was a comprehensive document that focused on the project's key messages. This included hiring two external BCC specialists, conducting a barrier analysis (Doer-Nondoer Survey), and carrying out Lot Quality Assurance Sampling (LQAS) at the midpoint to gauge the effectiveness of the behavior change activities.

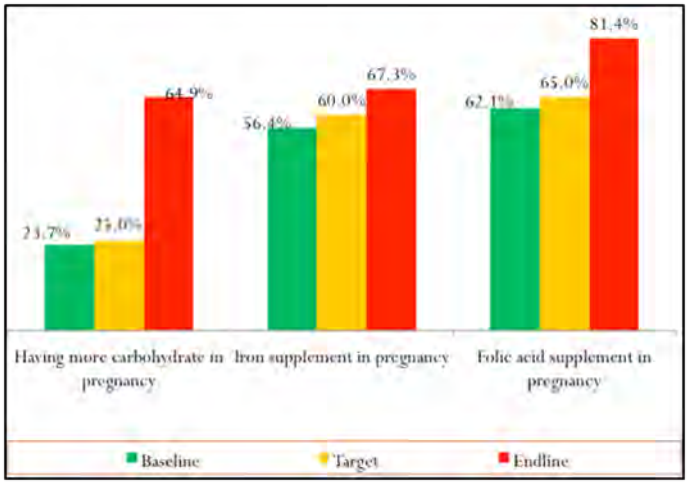
The LQAS and other midterm assessments showed that the project was not systematically including husbands and fathers. As a result, the project team and one of the consultants worked together to include activities for reaching men. Of the activities proposed for men, only one was

implemented fully: involving religious leaders. This was achieved by working with the Indonesian Moslem Leaders Assembly of West Jakarta to develop materials on "MCH from Islam's Perspective", using the USAID tool for materials development for religious leaders. Books, brochures and a pocket-sized reference were distributed to religious leaders for use during Koran studies meetings, Friday prayers and other gatherings. (See Annex XIX - C for a description of the materials.) Anecdotal evidence from community members and Hati Kami staff indicate that as a result, there is greater understanding of what Hati Kami is promoting and increased interest on the part of men in the project area, resulting in wider ***community engagement***. However, overall there are many missed opportunities to include men in the project, including male community leaders.

Other BCC activities that reinforced both IRs for Objective 1 and created high visibility for the project included: engaging community leaders and conducting community mobilization sessions, both of which increased ***community engagement***; periodic events such as media campaigns around breastfeeding; the production of 68 breastfeeding signboards; and the distribution of motivational materials and items with the key messages (e.g. umbrellas, tote bags, badges, hats and stationery.)

To ensure that messages on the key maternal/child care practices were consistent and that providers integrated counseling into routine contacts for maternal/child care, the project also devoted resources to improving the ability of health care providers to provide **effective counseling** in breastfeeding, Kangaroo Mother Care and IYCF. For example, 90 private midwives were certified as Breastfeeding Counselors after completing either the standard 40-hour WHO course or the self-paced blended learning course. Hati Kami also trained 20 IYCF trainers who in turn trained PHC staff as IYCF counselors throughout Jakarta Province. Note that these activities overlap with and reinforce Objective 2, which focuses on ***improving service delivery and the quality of maternal, newborn and infant services.*** Improving the technical skills of providers (e.g. breastfeeding counseling and Kangaroo Mother Care) seemed to give them greater confidence and more credibility with the beneficiaries. As one private midwife put it: *"Before Hati Kami I had the correct knowledge about breastfeeding but I didn't know how to persuade people, how to demonstrate the right positions, or how to answer their questions. Now I do – and I know how to make the learning environment fun!"*

Graph 2. Selected results for Objective 1: Maternal health



The second IR for Objective 1 (IR2) focuses on increasing social support for mothers as they begin to adopt new practices and behaviors; this IR also depends on an effective BCC strategy to achieve results. The Hati Kami strategy for this IR was two-fold: 1) provide tools to communities for better planning and management of activities to support mothers and 2) increase the capacity of West Jakarta stakeholders to scale up the MSG approach throughout West Jakarta Municipality. Discussions with mothers and KIIs with MHO personnel, project staff, and PHC heads showed that successful techniques included 1) working with religious leaders to develop materials on MCH and Islam, thereby encouraging more men

to support the project and 2) training community members in Household Financial Literacy, including the economic advantages of breastfeeding as opposed to buying breast milk substitutes. It is also worth noting here that the achievements for IR2 were also due in no small part to the activities for IR4, which focus on encouraging community members to advocate for local budget support for MCH activities.

Project Objective 2: Improved quality of maternal, newborn and infant services

Table 5. Summary of Inputs, Activities and Outputs that Contributed to Key Outcomes for Objective 2

Project Inputs	Activities	Outputs	Outcomes
IR 3. Increased skills and compliance of the health providers on Standard Based Management of Maternal and Child Health services and the baby friendly protocols			**Key Program Indicators** 1. Increase in percentage of mothers of children age 0-23 months who received counseling on breastfeeding or key maternal and infant care messages (from 40% to 79.7%) 2. Increase in percentage of mothers of children 0-23 months who received AMTSL after the birth of youngest child (from 30.0% to 43.6%). 3. Increase in percentage of health service providers' compliance in giving standard antenatal care (from 87.0% to 92.4%). 4. Increase in percentage of health service providers' compliance in giving standard normal delivery and newborn care (from 88.0% to 96.8%). 5. Increase in percentage of health care providers who gave standard post- partum and post-natal care (from 92.5% to 98.3%). 6. Decrease in percentage of pregnant women who received counseling on breastfeeding or key maternal and infant care messages (from 71.5% to 58.1%) **Other Indicator** 100% health facilities implemented at least 5 of the 10 steps (range 6-10 steps) to successful breastfeeding protocol by
SBMR Facilitators (MCHIP partners) Local Midwives Association (IBI) West Jakarta MHO staff Clinical Practice Facilitators SBMR check list booklet/ IEC materials Budget-share with Municipality and Province Health Offices Give2Asia/Johnson &Johnson Indonesia cost-share	SBMR workshops Participant assessments Evaluation meetings Series of capacity building seminars and workshops World Breastfeeding Week 2013 and 2014 commemoration in Jakarta Support for health providers' participation in seminars and workshops organized by Indonesian IBCLC Association	Practice of 40 participating midwives assessed against SBMR checklist 150 private midwives attended a seminar on Legal Aspects of Breastfeeding Support, Medical Records in Practice, Early initiation and EBF 62 public and private midwives in West Jakarta participated in practice training on Asphyxia Management and Neonatal Resuscitation, Kangaroo Mother Care and Partograph 26 counselors from West Jakarta and partners in the PHO participated in the national event on "Breastfeeding Update in Daily Practice" SBMR full adoption and roll out by Municipality Health Office of West Jakarta	
IR 4. Increased Use of MCH data for decision making and advocacy			
Government's *Musrenbang* Advisors and Consultant from District and City levels Trained male and female RW leaders Asia Foundation Indonesia's *Musrenbang* Guidelines MCH profiles in West Jakarta from City Health Office Rawa Buaya MCH population data registered with m-PWS	Training of RW leaders 2012 and 2013 Awareness raising roadshow in 8 RWs in 2012 Community participatory problem listing, analysis and priority rating in 2012 Advocacy and technical coordination (2012 -2014) *Musrenbang* proposal drafting by RW and sub-district levels	At least 670 male and female leaders and/or community figures were trained on Basic Knowledge on Maternal Child Health and Nutrition; bottom-up development planning facilitation; and MCH-friendly budget proposal and bottom-up advocacy Over USD $100,000 budget officially allocated for MCH activities for 2013-2014 and	

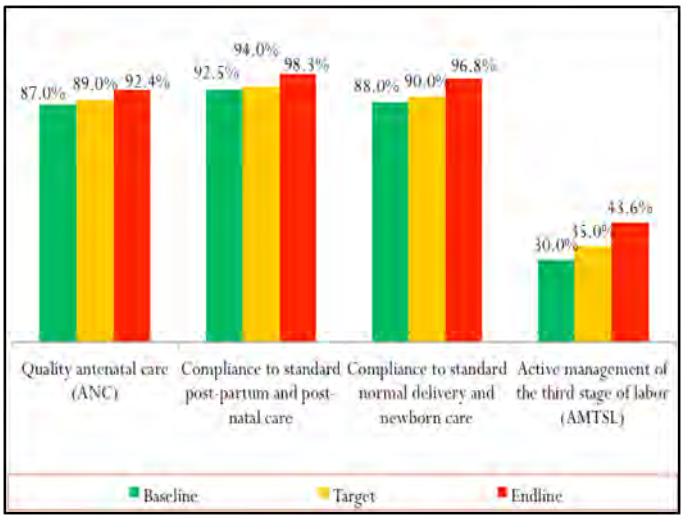
Project Inputs	Activities	Outputs	Outcomes
(specific to OR intervention area) Stationery supplies for meetings	(2012 and 2013)	2014-2015 in all 8 project sub-districts to conduct and leverage sub-districts' MCH initiatives (e.g. Mothers Support Group, opening up new *Posyandu*, etc.)	the end of the project.

To what extent did the project accomplish and/or contribute to the results stated in the DIP for Objective 2?

Of the six Key Program Indicators for Objective 2, five exceeded the target with statistical significance. What is especially encouraging is that the **quality of health services** for antenatal, delivery and postpartum care all improved, including Active Management of Third Stage Labor (AMTSL). As for the two indicators measuring access to counseling, the percentage of mothers of CU2 who reported receiving counseling during their last pregnancy nearly doubled (from 40% to 79.7%), but there was a disappointing decrease in the percentage of pregnant women who reported receiving counseling during their current pregnancy. Since the confidence intervals show that this latter result was statistically significant, it raises concerns about the extent to which providers, especially midwives, are counseling pregnant women on the essential maternal and child care messages, including breastfeeding.

To understand the impact of the **IR3 activities (**Increased skills and compliance of the health providers), the evaluation team interviewed providers (private midwives and PHC staff); partners, including IBI, PKK and the MHO; and beneficiaries. Both groups of providers noted the same things about the skills training they had received: it improved their technical skills and their skills in counseling and effective communication, raised their confidence level, and as a result, brought them closer to the communities they serve.

Graph 3. Selected results for Objective 2: Quality of health care services



One of the most effective strategies for improving the quality of services was to take the SBMR tool developed by MCHIP and adapt it for use with private midwives. (Adaptation included, for example, removing the checklist for integrated management of childhood illnesses and replacing it with a checklist for exclusive breastfeeding support/counseling.)

> *"We had to fight a little the first time but now they know me at the district office and realize that I will be a regular visitor, making sure we receive the allocation for the MSGs."* (Comment from an MSG Mentor who was also trained in Financial Advocacy.)

Improving the skills of private midwives is crucial in the project area since the majority of women go to them rather than to public facilities. With solid support from the MHO and IBI, this initiative has now been scaled up and the adapted tool is being rolled out throughout West Jakarta, a result that will be one of the lasting legacies of Hati Kami according to the West Jakarta Director of Public Health. This activity was not in the original

project proposal design and is a good example of the project team's willingness to adapt, to take risks and to be innovative.

As for IR4 (Increased use of MCH data for decision making and advocacy), the results are mixed due to the fact that OR is included under this IR and the expected OR results have not all been achieved. Leaving OR aside, the qualitative KIIs and a review of recent project documents indicate that the project has succeeded in helping communities use data to support MCH activities and to advocate for local budget contributions to these activities, including MSGs. One of the more interesting achievements was getting community leaders and ordinary citizens involved in *Musrenbang*, the bottom-up local budgeting process that provides an opportunity for the community to propose items for the budget. In the past, communities tended to propose infrastructure but as a result of training in advocacy and budgeting, communities in all eight sub-districts succeeded in getting over $100,000 in allocations for MCH activities for the 2013-2014 and 2014-2015 budget cycles. Those interviewed as Key Informants declared that they were encouraged by their success to date and planned to advocate on a regular basis to ensure that MCH activities such as MSGs and *Posyandu* continue to benefit from the annual *Musrenbang* process.

Factors Contributing to Success

Based on the qualitative results, including observations, and the document review, it is possible to discern some of the factors that contributed to the project achieving its Objectives; these factors can be grouped into three categories: program design; partnerships; and community engagement. Under program **design**, the following points stand out: lessons learned from the previous Jakarta-based breastfeeding project, Healthy Start, were incorporated; the design is relatively simple and tightly focused; there is an inherent logic between the two Objectives (improving practices of mothers and improving the skills of providers); and the design responds directly to the priorities of both the MoH and the USAID Mission.

Strong partnerships were one of the hallmarks of Hati Kami; this included the partnerships within the Hati Kami team and the partnerships between Hati Kami and its partners. The lead evaluator observed that the 11-member Hati Kami team is extremely close-knit and their complementary skill sets (technical, management, leadership, facilitation) enable them to jointly tackle challenges. Although there has been some turnover within the team over the four years of project implementation, the Health and Nutrition Program Manager provided the leadership to maintain the team spirit and drive. Characteristics that define this team include adaptability when confronted with challenges and responsiveness. For example, when some midwives were unable to take a week off to participate in the 40-hour breastfeeding counseling course, Hati Kami found a solution: they submitted a funding proposal to Johnson & Johnson to develop and pilot a blended learning course (self-directed) for breastfeeding counseling skills. When the funding was approved, the team worked with Health[e] Foundation to develop the online course. The team members are responsive to requests for assistance whether they come from the Governor's office, the MHO, a PHC or a community group. At the MHO's request, for example, they developed written guidelines and manuals for MSGs and m-PWS.

During the qualitative field work and the Stakeholders Workshop, the lead evaluator observed the extremely close working relationship between the Hati Kami team and its partners, specifically the MHO, IBI, PKK and the staff at the PHCs. It would appear that the team has paid careful attention to establishing effective working relationships with the result that these organizations provide excellent support, including financial support in the form of sharing budgets for some activities. The Mercy Corps Country Director also commented on this during

the Stakeholders Workshop, saying that the lively interaction between the government representatives and the Hati Kami team was atypical.

Contributing to project achievements is the focus on **involving the community**. This includes incorporating the CHVs and community leaders into project implementation, including the m-PWS and IYCF; using the MSG approach to reach women who might be new to a community and feeling isolated; helping to bridge the gap between health care providers and the community by promoting financial advocacy so that providers and community members make decisions together; employing a variety of social mobilization techniques to reach households with the key messages for improving maternal and child health; and using m-PWS to register mothers and young children so they can more easily be tracked. For this last activity, one PHC head noted that they were able to use the m-PWS data to locate mothers and young children during one of Jakarta's periodic floods.

OR Findings

In evaluating the major activities undertaken by Hati Kami, the most problematic has been the OR. Of the six research questions in the OR design, the first three (accuracy of reporting, timeliness of reports and level of participation) could not be answered due to either a lack of data for certain periods or incomplete data. Sufficient data was available to answer Question 4 – use of MCH data for local planning. Utilization was not higher in the m-PWS area for internal planning but was higher in the m-PWS area for the quarterly planning sessions between the Rawa Buaya PHC and the community.

The last two research questions concerned barriers and enabling factors for the use of the m-PWS and there was useful data generated for these questions. Question 5 concerns enablers and barriers to using m-PWS for health care providers and CHVs. Enabling factors include:

- Data collection and reporting using m-PWS was affordable
- The m-PWS forms were easy to use and reporting was convenient and practical
- The activity encouraged community leaders to participate

Some of the barriers cited by providers and CHVs during the study were:

- Private midwives relied on their own sub-standard registers to complete the forms but were often missing data that they do not routinely collect. This led to delays in submission of their reports.
- Time was a factor for the private midwives, with half of them relying on their assistants to complete the m-PWS forms. As a result, data quality was not always optimal.
- Since the PHC and private midwives in the intervention area still had to complete the paper-based forms, it seemed to some like an extra burden to also use m-PWS.
- The use of mobile technology requires a robust infrastructure to function well. In the absence of such an infrastructure, dedicated technical assistance is needed for the users.

The final OR question concerned the government's perception of enabling factors and barriers for scaling up. An important enabling factor is the government's desire to continue m-PWS as it is more accurate and valid than the paper-based system. It also allows health providers to better track people in their catchment area. According to the MHO, their budget can accommodate the PHC-level expenses for using m-PWS. But the government also has some concerns: need for technical support; turnover of staff who may be trained in m-PWS, resulting in need to train new staff; additional budget needed for the initial training and for ongoing technical assistance; and need for a formal agreement with private providers to ensure that they also participate in m-PWS.

Some of the **obstacles encountered** during OR implementation were beyond the project's control: floods, the departure of the key investigators to pursue graduate studies, a series of elections, and lengthy delays in securing the necessary approvals to move forward. Other obstacles, however, could have been anticipated and/or addressed sooner: the need to switch the intervention area and the control area due to a dearth of private midwives in the original intervention area; the lack of monitoring to ensure that both the intervention and the control areas were submitting complete records on a regular basis; and insufficient oversight of the OR Research Partner to ensure accountability.

In spite of the problems encountered, the OR initiative has resulted in a number of **positive benefits**. By demonstrating the potential of mobile technology, it raised the awareness of stakeholders, including the USAID Mission, of the advantages of this technology and generated widespread interest within the PHO in using mobile technology for monitoring and tracking. In the KIIs conducted as part of the qualitative evaluation, both the head of the Rawa Buaya PHC and the West Jakarta Public Health Director expressed their desire to continue using a mobile system and to eventually replace the paper-driven system. Other PHCs in the project area are also clamoring for the technology. Another positive effect is the increased level of ***community engagement***. More than 400 volunteers and community leaders are collecting data and as a result, community leaders say they have a much better idea of who is in their community. The Rawa Buaya staff also noted that this technology allows them to track people better and brings them closer to the people they serve.

CONCLUSIONS

Although the qualitative exercise did show that people hear health and nutrition messages from a variety of sources (e.g. via Hati Kami, from radio and television, and from the Internet), the results described above can largely be attributed to Hati Kami as there are no similar projects in the area that could have produced this combination of results. Overall, after reviewing and discussing the quantitative data and corroborating evidence from the qualitative evaluation and a detailed document review, the evaluation team concluded that **Hati Kami has been successful, achieving both of its Objectives and most of the intended results**. In addition, the project team has enhanced the original design described in the project proposal by achieving measurable results with the addition of innovative activities such as adapting SBMR for private midwives and providing financial advocacy training for community members.

Which elements of the project have been or are likely to be sustained or expanded?

Sustainability includes both ensuring that the positive effects of the program endure and that successful activities and initiatives are continued and scaled up. Among the **positive effects** that seem likely to continue based on discussions with mothers and MSG Motivators and Mentors are the following:

- Many mothers will continue the improved practices they have adopted and some will share what they have learned with friends and relatives.
- The private midwives and other health care providers interviewed stated that they plan to continue practicing what they learned during the trainings.
- Those trained in financial advocacy appear committed to continuing to secure funding for MCH activities in their communities during the annual budget cycle negotiations.
- The trainers trained in breastfeeding counseling and IYCF will continue to train others.

As for activities that are likely to continue, the MHO and IBI are already scaling up SBMR for private midwives throughout West Jakarta. And some MSGs will continue depending on the motivation of the Mentors and Motivators. As for m-PWS, there is strong interest in replicating this system in West Jakarta but a number of hurdles, including budget, need to be resolved.

What were the conclusions reached for the four Learning Themes?

The evaluation team consolidated their conclusions based on the quantitative and qualitative results:

1. **Community Engagement**

   - The MSG is an effective forum for reaching people (especially women) with the right information.

   - Hati Kami facilitated access to the community for the PHC staff, leading to higher attendance, better knowledge of population and its problems and greater achievement of PHC targets.

   - Hati Kami brought private midwives closer to potential clients. As one midwife said during her KII: "I have become closer to the community."

   - Involving the community, especially RW and other leaders, resulted in increased local funding for maternal and child health activities.

   - The CHVs and community leaders were highly visible during activities, lending credibility to the OR and building community capacity for data collection and analysis.

   - Effective strategies for community engagement included: networking (e.g., PKK); training and capacity building for CHVs and community leaders; creating MSGs; and reinforcing public/private partnerships by involving private midwives

2. **Service Delivery and Quality**

   - The project helped to increase the use of PHC service (sources: PHC staff and beneficiaries).

   - There were quality improvements in services, especially for pregnant women and newborns both at PHCs and from private midwives (endline surveys and assessments)

   - Strategies to promote use of services and to improve quality included: BCC via MSGs; use of improved data to locate pregnant women and mothers of children 0-23 months; training in maternal and neonatal care for public and private providers; introduction of SBMR, a self-monitoring tool for midwives; leveraging ongoing funding for maternal and child health services; and reinforcing the partnership with IBI.

3. **Scale up and Sustainability**

- MSG was scaled up.
- Motivators, Mentors, religious leaders, and community volunteers and leaders were trained to ensure the continuation of MSGs, with oversight and support from PHCs.
- SBMR was introduced to West Jakarta and is now being scaled up by the MHO and IBI for lasting improvements in quality health care.
- The use of mobile technology for LAMAT was piloted and the MHO is very interested in taking it to scale.
- Trained community leaders and other stakeholders plan to continue to lobby for increased local funding for MCH activities.
- Manuals were developed for MSG; m-PWS; and religious leaders.

4. **Learning and Adaptation**

- Operations Research: The Rawa Buaya PHC and the MHO want a mobile monitoring and tracking system to replace the manual system because it provides real time data, allows for cross-checking, provides more accurate population data and facilitates access to pregnant women and CU2.

RECOMMENDATIONS

Findings	Conclusions	Recommendations	Who is Responsible?
Gender: Project activities focus primarily on women.	There are missed opportunities to involve husbands and fathers in activities that would support their wives.	Develop additional outreach activities for men, using some of the strategies proposed in the midterm review of the BCC strategy.	Stakeholders who plan to scale up the MSG approach; those designing new MSG projects
Community leaders: Although community leaders are involved to some extent in social mobilization and m-PWS, there is no defined strategy to incorporate them for fully into design, implementation and evaluation.	Involving community leaders – elected, appointed, informal – more fully could increase the impact of the project and enhance sustainability.	Develop a series of seminars/trainings specifically for male and female leaders. Include an introduction to adult learning and behavior change at the beginning of the project.	Stakeholders interested in replicating or adapting the project design
Less than 15% of eligible women are members of an MSG.	There are missed opportunities to reach pregnant women and mothers of young children.	Work with health providers, community leaders, CHVs, and current MSG groups to determine why women are not enrolled. (This may include a barrier	Stakeholders who plan to scale up the MSG approach; those designing new MSG projects

Findings	Conclusions	Recommendations	Who is Responsible?
		analysis.) Develop strategies to overcome obstacles to enrollment.	
Motivators drop out for various reasons, often because they find full-time employment, move out of the neighborhood or become bored with the routine of the MSG meetings.	Frequent turnover disrupts the MSG, sometimes resulting in missed sessions and/or participants dropping out.	Identify Motivators with a strong potential for remaining with the program, e.g. the wives of community leaders who are less likely to move and female religious leaders.	Stakeholders who plan to scale up the MSG approach; those designing new MSG projects
The endline KPC survey showed that the majority of pregnant women report that they are not counseled on breastfeeding or maternal and child care during their pregnancies.	These missed opportunities for counseling could have a negative impact on pregnant women and their children.	Conduct an analysis to determine why pregnant women do not receive counseling. Include PHC staff, pregnant women, CHVs, IBI, and private midwives in the analysis and problem-solving. Since the majority of pregnant women receive their care from private midwives, make counseling one of the mandatory competencies for private midwives	MHO, PHC staff, IBI and private midwives PHO, MHO, IBI
Although BCC activities were taking place in the first half of the project, the strategy was not fully developed until Year 3.	A focused, comprehensive BCC strategy would be more effective if available early on in the project.	Ensure that the BCC strategy is developed within the first six months of project start-up and that it is based on formative research. Use LQAS or other cost-effective ways to periodically monitor the effectiveness of the strategy and to make course corrections as necessary.	Those designing new projects
Much of the data needed to answer the OR questions was missing or incomplete.	It was not possible to answer three of the six research questions, undermining the usefulness and applicability of the OR.	Put in place a rigorous system for monitoring and oversight of the OR to ensure that all the necessary data is available and of high enough quality to be useful.	Those designing and implementing future OR activities.

ANNEX III. PROJECT MANAGEMENT EVALUATION

Using Key Informant Interviews (KIIs), document review, and observations of people interacting, the Lead Evaluator did not discern any major management issues that might have impeded implementation or negatively affected the quality of the project's outcomes. On the contrary, there are a number of management practices that appear to have contributed to the success of the project. A brief summary for each practice is provided here.

Joint Planning and Implementation with Partners

The project was designed in close collaboration with the Ministry of Health (MoH), especially the Provincial Health Office for Jakarta Province (PHO), the Municipality Health Office (MHO) for West Jakarta and administrative authorities at the local, mayoral and provincial levels. This included choice of sites and activities. This practice of close collaboration with the MoH and with other partners such as the Indonesian Midwives Association (IBI) has continued during the four years of implementation, including the preparation of the Detailed Implementation Plan (DIP) at start-up and the Final Evaluation at the end.

One of the strengths of Hati Kami is the extent to which the partners are responsible for execution. The presence of the key organizational partners in implementation is especially evident in the descriptions of trainings and in the introduction of new activities such as the use of Standards Based Management and Recognition (SBMR) to improve the quality of services provided by private midwives. Partners are also involved in evaluation as evidenced by the four representatives of IBI and the MoH on the qualitative evaluation team.

That this close collaboration has enhanced the potential for sustainability is clearly evident on a number of fronts. IBI and the MHO, for example, have already started to roll out SBMR for other midwives in West Jakarta Municipality who are not in the project zone. According to the Public Health Director for West Jakarta Municipality, the MHO is also keen to continue to roll out the Mothers Support Groups (MSG) and to follow up on the use of mobile technology for data collection. When the MHO requested that Hati Kami prepare manuals to guide them post-project, the team put together two sets of manuals, one for MSGs and one for the m-PWS system. This willingness of the Hati Kami team to respond positively to partners' requests for additional resources has done much to reinforce the obviously close ties between the Hati Kami team and its organizational partners at all levels.

Financial Management

The Mercy Corps/Indonesia Health and Nutrition Program Manager (HNPM) manages the Hati Kami project. According to the Mercy Corps/Indonesia Finance Director, who has been involved with Hati Kami since the proposal development stage, the HNPM has been very "active" in the project's financial management. She conscientiously monitors the Hati Kami budget, including the cost share and match contributions. As part of her financial management responsibilities, she meets at least monthly with members of the Finance Team to query expenses and to propose adjustments. The Finance Director also noted that the burn rate was consistent, there were no financial crises and the project was on track to complete spending by the end of the grant period.

A second positive aspect of financial management is the fact that Mercy Corps exceeded its match, procuring 116% of the required match to date with the possibility of additional funds before the official project closing. The match included community contributions, cost share from organizational partners, and grants from the private sector, including a substantial grant from

Johnson and Johnson, which the HNPM was instrumental in obtaining. Also noteworthy is the extent to which Indonesian Government partners, especially the Municipal Health Office and the Provincial Health Office, agreed to cost-share certain budgets, primarily for training and seminars. Over the course of the project they have contributed approximately $30,000, demonstrating their commitment to the project's goals and their appreciation of what Hati Kami has accomplished.

Although funding was adequate over the four years, the HNPM did note that with additional financing, the project could have added additional BCC activities, especially for social mobilization.

Human Resources Management

The Hati Kami team is composed of 11 full-time Mercy Corps employees, all of whom are technical staff except for the Program Admin Officer. The Lead Evaluator decided to interview all 11 because with the exception of the four District Coordinators, each team member has a distinct role in the project.

One of the strengths of this project is the quality of the Hati Kami team. They are well-qualified, have complementary technical and managerial skills and among them have decades of development experience in health and other sectors. Three of the team members, including two of the four District Coordinators responsible for overseeing the field activities, were part of the Healthy Start project, the previous CSHGP project implemented by Mercy Corps in Jakarta Province. A third District Coordinator had experience with the MCHIP project. The Mercy Corps HNPM, who manages the project, also has extensive experience with health programming and prior management and finance experience. She has been with the project since the beginning, assuring continuity and providing charismatic leadership.

Although there has been some staff turnover and shifts in responsibilities during the four years of project implementation, this does not seem to have had a lasting negative impact on project operations. The team is exceptionally close-knit, with collaboration and mutual assistance characterizing their interactions with each other and with their partners. Inspired perhaps by the example set by the HNPM, they are not afraid to take calculated risks, to try out new techniques and to initiate new activities. The Mercy Corps/Indonesia Country Director said he considers the team as a "role model" for other teams in the organization.

All the team members seem keen to develop new skills and thanks to the leadership of the HNPM, they have been able to do this within the context of Hati Kami. One of the District Coordinators, for example, was originally an admin person on the project but was very interested in working in the field as a District Coordinator. With the support of the HNPM and extensive mentoring provided by the other District Coordinators, he progressively took on the oversight of project activities in a number of communities and apparently has done well in his new role. Another example is the Program Admin Officer. The HNPM encourages all staff to visit project activities no matter what their role is. As a result, the Admin Officer became interested in the Mothers Support Groups and participated in a training for new MSG Motivators. As a result she has informally become a Motivator in her own community, working with mothers and other caretakers of young children such as grandmothers.

During their interviews with the Lead Evaluator, the team members talked about the new skills they had been able to develop as a result of working on this project. As one of them noted, the HNPM continually encourages them in their professional development, working with them to

determine what competencies they need to develop and giving them the opportunity to attend trainings and to try out these new competencies. Among the skills they have developed, several of them noted facilitation and training skills and the Lead Evaluator observed this first hand during the Final Evaluation: Following the qualitative field work, the Lead Evaluator planned to facilitate a one-day workshop with the evaluation team to analyze results and to make recommendations. However, the HNPM asked that the Hati Kami staff be allowed to review the workshop design, revise where necessary and facilitate the various sessions themselves rather than the Lead Evaluator doing everything. The Hati Kami team did an outstanding job and clearly demonstrated their ability to bring participants together for a productive, fun workshop.

Technical and Administrative Support

During the four years of the Hati Kami project, there was somewhat high turnover within Mercy Corps/Indonesia (two Country Directors and three different Deputy Directors for Program) and in the health department at Headquarters (two Public Health Directors with a gap of several months between Directors). This did not seem to have had a serious impact on project implementation. Technical support from Mercy Corps Headquarters seems to have been perfectly adequate. The first Public Health Director visited the project during the DIP process. In the gap between his departure and the arrival of the current Public Health Director, Mercy Corps Headquarters hired an experienced public health nutritionist as an interim person to oversee the health sector. She provided virtual support to Hati Kami over a period of several months and also made a technical visit. During her visit, she worked with the staff on a number of themes including BCC. The second Public Health Director came on board in January 2013 and has provided continuous guidance and support, including two technical visits.

ANNEX IV. WORK PLAN TABLE

No	Project Activities	Project Year October - September (v=completed; x=dropped)				Status as of September 29, 2014
		FY11	FY12	FY13	FY14	
1	Inception Meetings/ Workshops	V				Achieved
2	Assessments					
	Baseline KPC survey	V				Achieved
	Qualitative Assessment	V		V	V	Achieved
	Additional baseline assessments - Maternal KPC and Health Facility Assessment		V			Achieved for maternal KPC. Health facility assessment: dropped.
	Finalizing plan of Operational Research (with partner)		V			Achieved
	Mid Term Evaluation			X		Dropped: Not required. Did internal assessment and LQAS instead.
	Endline KPC survey and additional assessments				V	Achieved
	Final Evaluation				V	Achieved
3	Reporting					
	DIP Workshop with partner	V				Achieved
	DIP Finalization and consultative meetings	V				Achieved
	Annual Report		V	V		Achieved
	IR 1. Increased knowledge and skills of mothers on breastfeeding and key maternal-newborn care					
	Strategy: Replicate Mothers Support Groups with new expanded model					
1.1	Revision of existing Mothers Support Group (MSG) to include maternal-newborn care and maternal nutrition topics		V	V	V	Achieved
	Internal Workshop to expand the MSG model to fit the					

No	Project Activities	Project Year October - September (v=completed; x=dropped)				Status as of September 29, 2014
		FY11	FY12	FY13	FY14	
	urban Jakarta poor residents context					
	MSG Review Workshop with key implementers in Mercy Corps Indonesia working area					
	Internal Workshop to extract key messages on desired behavior for maternal nutrition and 5 steps to fight diarrhea to MSG mentoring and modules					
1.2	Roll out MSG replication in 8 sub-districts of West Jakarta		V	V	V	Achieved
1.3	Mothers Support Group Motivators' performance assessment and reward			V	V	Achieved
	Production of MSG training materials (modules, mentoring sheets, etc.)	V	V	V		Achieved
Strategy: Integrate counseling on maternal-infant health and nutrition into the 7+ contacts in maternal-newborn care						
1.4	Training of Trainers for Breastfeeding Counseling & Kangaroo Mother Care (KMC)		V			Achieved
1.5	Breastfeeding Counseling & Kangaroo Mother Care Trainings		V	V	V	Achieved
1.6	Socialize integration of counseling into maternal, newborn, child health care services (*Private Midwives, Posyandu, Puskesmas, Mothers Support Groups)*		V	V		Achieved
	IR 2. Increased access to social support for mothers on breastfeeding and key maternal-newborn care					
Strategy: Implement contextualized and targeted communication strategy						
2.1	Initial qualitative assessments to identify priority behaviors, target groups and influencing factors and recommended project activities from compiled information obtained from existing studies, notes from community meetings, and notes from stakeholder consultations during the first year of Hati Kami project.		V	V		Achieved
2.2	Work with experienced MCH/IYCF-BCC Consultant to design comprehensive BCC strategy which includes an additional qualitative assessment, design of messages		V	V		Achieved

No	Project Activities	Project Year October - September (v=completed; x=dropped)				Status as of September 29, 2014
		FY11	FY12	FY13	FY14	
	and tools, field testing and refining.					
2.3	Production and distribution of tailored communication tools			V	V	Achieved
2.4	Participate in and/or support local and national maternal, infant, child health and nutrition fora	V	V	V	V	Achieved
	IR. 3. Increased skills and compliance of the health providers on MCHN counseling, Active Management of Third Stage Labor, essential newborn care, and the baby friendly protocols.					
Strategy: Adopt and replicate the MCHIP developed Standard Based Management and Recognition (SBMR) approach for private midwives						
3.1	Formation of a project team for quality improvement activities (SBMR)		V			Achieved
3.2	Adaptation and testing of tools to the project setting		V			Achieved
3.3	Training of supervisors in using the tools		V			Achieved
3.4	Implementation of the self-assessment tool and action planning during mentoring visits		V	V		Achieved
3.5	Compilation of findings, review, and documentation of achievements/progress		V	V		Achieved
Strategy: Support the Municipality Health Office and Indonesian Midwives Association to train providers on Kangaroo Mother Care method						
3.6	KMC mini seminar/course – with other breastfeeding themes and SBMR follow up refresher course (*included asphyxia management, infection control*)		V	V		Achieved; cost-share with MHO
Strategy: Adopt and replicate the 10 steps to successful breastfeeding model of Healthy Start (former Mercy Corps' CSHGP project)						
3.7	A municipality level workshop to introduce the idea and review standards			X		Dropped in FY13
3.8	Initial assessment of health facilities by a sub-district team, development of plans of action and health facilities to make adjustments in response.			V		Achieved
3.9	Competition to see progress in implementing SOS			X		Dropped in FY13 because in Jakarta, the WHO-UNICEF's 10 baby-friendly steps in maternity care have been reinforced by the Jakarta PHO. The West
3.10	Assessment, feedback, and reward for most improvement			X		

No	Project Activities	Project Year October - September (v=completed; x=dropped)				Status as of September 29, 2014
		FY11	FY12	FY13	FY14	
						Jakarta MHO has also promoted it and raised hospitals' awareness about the importance of the baby friendly steps. Therefore, Hati Kami did not replicate the "Healthy Start's agreement to 10 Steps" intervention model in West Jakarta.
	Final assessments of SBMR for private midwives and baby-friendly protocol in health facilities in project area (with Indonesian Midwives Association)				V	New activity in FY13 and was achieved
	IR. 4. Increased use of maternal and child health data for decision making and advocacy					
Strategy: Test and document the use of mobile technology to improve the use of quality data to inform local planning and resource allocation for better MCH interventions and outcomes						
4.1	Operations Research					
	Consultative Meetings with Implementing Partners &/ Advisory Board	V	V	V		Achieved
	Baseline studies		V			Achieved
	Report of Baseline studies			V		Achieved
	LAMAT refresher workshop with Ministry of Health for intervention and control area		V			Achieved
	Field preparation for m-PWS (mobile LAMAT)		V			Achieved
	Formative study (mid-term)		V			Achieved
	Report of mid-term study				V	Achieved
	m-PWS roll out in *Rawa Buaya* (training, on-the job, workshops)			V	V	Achieved
	Endline Evaluative Study & report				V	Achieved
	Dissemination & Feedback workshop to Stakeholders				V	Achieved
Strategy: Support the sub-district level to establish quarterly MCH problem solving discussion at the community level						
4.2	Facilitate quarterly workshops in 8 sub-districts using MCH data to develop local actions plan and to monitor progress of the ongoing MCH programs		V	V	V	Achieved
4.3	Participation/ facilitation of Musrenbang at sub-district, district, and municipality levels (Musrenbang: annual		V	V	V	Achieved

No	Project Activities	Project Year October - September (v=completed; x=dropped)				Status as of September 29, 2014
		FY11	FY12	FY13	FY14	
	planning and budgeting process)					

ANNEX V. RAPID CATCH TABLE

Indicator	Baseline Estimate (%) 30 Cluster	MTE Estimate (%) LQAS	Final Estimate (%) 30 Cluster
Maternal TT Vaccination: *% of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child*	*8.7*	*NA*	*67.0*
Skilled Delivery Assistance: *% of children age 0-23 months whose births were attended by skilled personnel*	*98.7*	*98.9*	*99.7*
Exclusive Breastfeeding: *% of children age 0-5 months who were exclusively breastfed during the last 24 hours*	*23.4*	*51.6*	*42.7*
Vitamin A Supplementation in last 6 months: *% of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall*	*63.1*	*NA*	*58.3*
Measles Vaccination: *% of children age 12-23 months who received a measles vaccination*	*88.2*	*NA*	*90.9*
Access to Immunization Services: *% of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey*	*55.3*	*62.6*	*59.6*
Health System Performance on Immunization Services: *% of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey*	*43.5*	*NA*	*60.6*
Treatment of Fever in Malaria Zone: *% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began*	*N/A*	*NA*	*NA*
ORT Use: *% of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home*	*34*	*17.1*	*73.3*

fluids			
Appropriate Care Seeking for Pneumonia: *% of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider*	*88.9*	*NA*	*57.1*
Point of Use (POU): *% of households of children age 0-23 months that treat water effectively*	*55*	*NA*	*63.6*
Appropriate Handwashing: *% of mothers of children age 0-23 months who live in households with soap at the place for hand washing*	*17.3*	*33.1*	*23.3*
Child Use of ITNs: *% of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night*	*NA*	*NA*	*NA*
Underweight: *% of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)*	*10.5*	*NA*	*13.9*
Infant and Young Child Feeding: *% of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices*	*35.1*	*97.7*	*26.7*
Antenatal Care: *% of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child*	*91.3*	*99.6*	*83.9*
Current Contraceptive Use: *% of mothers of children age 0-23 months who are using a modern contraceptive method*	*68*	*0*	*72.1*
Post-natal visit for newborn: *% of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth*	*59.3*	*89.1*	*73.3*

ANNEX VI – A. FINAL KNOWLEDGE, PRACTICE, AND COVERAGE REPORT

FINAL KNOWLEDGE, PRACTICE AND COVERAGE REPORT

USAID Cooperative Agreement No. AID-0AA-A-10-00063

Submitted December 2014

MERCY CORPS / Indonesia

In cooperation with:
The Municipal Health Office of West Jakarta
The Governments of Cengkareng and Kalideres Districts in West Jakarta

Author: Gunawan Meliyandoko

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Maternal Nutrition KPC Survey:

- Supervisor: Gunawan Meliyandoko, S.Sos (Criminology)
- e-questionnaire conversion support: Didit Agus Irwantoko, S.E, S.Komp, MM candidate.
- Enumerators:

1. Anik Kurniati, S.KM (Public Health graduate)
2. Ester Novalia Tambunan, Am.Keb, S.KM (Midwife and Public Health graduate)
3. Fazryani Mazita Torano, S.KM (Public Health graduate)
4. Hafni, S.KM, M.KM candidate (MPH candidate)
5. Herawati Marito Sihombing, S.Sos (Anthropology)
6. Karina Nurmy, S.KM (Public Health graduate)
7. Mumfaridah, S.KM (Public Health graduate)
8. Nor Alfiyah, S.KM (Public Health graduate)
9. Rebecca Sihimbing, Am.Keb, S.KM (Midwife and Public Health graduate)
10. Septia Risti Rahmah, S.KM, M.KM candidate (MPH candidate)

Infant and Young Child Health and Feeding KPC Survey:

- Supervisor: Gunawan Meliyandoko, S.Sos (Criminology)
- e-questionnaire conversion support: Didit Agus Irwantoko, S.E, S.Komp, MM candidate.
- Enumerators:

1. Anik Kurniati, S.KM (Public Health graduate)
2. Ester Novalia Tambunan, Am.Keb, S.KM (Midwife and Public Health graduate)
3. Herawati Marito Sihombing, S.Sos (Anthropology)
4. Karina Nurmy, S.KM (Public Health graduate)
5. Mumfaridah, S.KM (Public Health graduate)

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ACRONYMS AND TERMS

AMTSL	Active Management of the Third Stage of Labor
BCC	Behavior Change Communication
BFC	Breast Feeding Counseling (refers to the WHO standard 40 hours course)
BFHI	Baby Friendly Hospitals Initiative
CSHGP	Child Survival and Health Grants Program
CU2	Children under 2 years of age (0-23 months)
HNPM	Health and Nutrition Program Manager (Mercy Corps/Indonesia)
IBI	*Ikatan Bidan Indonesia* /Indonesian Midwives Association
IMCI	Integrated Management of Childhood Illnesses
IR	Intermediate Result
IYCF	Infant and Young Child Feeding
Kader	Community Health Workers
KPC	Knowledge Practice and Coverage Survey
LAMAT	Local Area Monitoring and Tracking
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MCHN	Maternal and Child Health and Nutrition
MHO	Municipality Health Office / *Suku Dinas Kesehatan Kota*
MoH	Ministry of Health /*Kementrian Kesehatan*
m-PWS	Mobile Area Monitoring and Tracking (*Sistem Pemantauan Wilayah Setempat secara Mobil*)
MSG	Mothers Support Groups
OR	Operations Research
PHC	Public Health Center (*Puskesmas*)
PHO	Provincial Health Office / *Dinas Kesehatan Provinsi*
Posyandu	Village Health Posts (*Pos Pelayanan Terpadu*)
PHC	Public Health Center (*Puskesmas*)
RT	Neighborhood of 30 to 60 households (*Rukun Tetangga*)
RW	A cluster of 8 to 19 neighborhoods (*Rukun Warga*)
SBMR	Standards Based Management and Recognition
SOS	*Setuju Oentoek Sepuluh* (agree to 10 steps to successful breastfeeding) – a Mercy Corps adaption of the Global Baby Friendly Hospital Initiative assessment tool for the context of hospitals, primary public health service centers, and private maternity clinics in urban Jakarta
WHO	World Health Organization

BACKGROUND

From October 2010 through September 2014 Mercy Corps Indonesia implemented a four-year Child Survival and Health Grants Program (CSHGP) Project, "*Hati Kami*," in eight sub-districts of the Cengkareng and Kalideres Districts of West Jakarta Municipality, Indonesia. The goal of the project was to promote, support, and protect the mother-child dyad for a healthy start among Jakarta's poor residents. The goal was to be achieved through two Objectives and four Intermediate Results (IR):

Objective 1. Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life

- *IR1. Increased knowledge and skills of mothers on breastfeeding and essential maternal-newborn care*
- *IR2. Increased access to social support for mothers on breastfeeding and essential maternal-newborn care*

Objective 2. Improved quality of maternal, newborn and infant services

- *IR3. Increased skills and compliance of the health providers on Maternal and Child Health and Nutrition (MCHN) counseling, Active Management of the Third Stage of Labor (AMTSL), essential newborn care, and the baby friendly protocols.*

To achieve these objectives, the program implemented the following major activities:

1. Replicated and advanced the community-based Mothers Support Group (MSG) model that was developed in the previous CSHGP project, "*Healthy Start*"
2. Designed and implemented Behavior Change Communication (BCC) for improved maternal, newborn and child health practices
3. Adapted the Maternal and Child Health Integrated Program (MCHIP) tools for Standards Based Management and Recognition (SBMR) for maternal and newborn health services
4. Tested an innovative strategy to track and monitor utilization and quality of maternal and newborn health services using a rapid analysis software, LAMAT[1] and mobile-phone technology.

Throughout the four years of implementation, the following key results were achieved:

- 94 communities (*Rukun Warga* or RW, a cluster of 8-19 neighborhoods) have functioning Mother Support Groups to support pregnant women and mothers of children under 24 months in improving key health behaviors for optimal maternal and child health and nutrition;
- A sermon module which shares key messages for optimal behaviors in pregnancy and lactation and key practices for children < 2 years, has been developed by Muslim leaders and distributed to all local Muslim leaders in Cengkareng and Kalideres Districts;

[1] LAMAT stands for Local Area Monitoring and Tracking. It is a computerized version of the MoH maternal-child local area monitoring (PWS-KIA).

- All eight sub-districts in the project area have formally budgeted for efforts to support mothers of children <2 and pregnant women through the *Musrenbang* (local planning and budgeting) process;
- As a result of SBMR activities, 40 midwives are complying with the maternal and newborn health service standards;
- One Public Health Center (PHC – *Puskesmas*) has tested the use of mobile data collection for LAMAT.

The success of the program in achieving the two Objectives was measured by comparing the project indicators at baseline and endline. These indicators were laid out in the approved monitoring and evaluation (M&E) plan. Baseline surveys were completed in February 2011 (Knowledge, Practice and Coverage or KPC Survey) and April 2012 (Maternal Nutrition Survey). As the program was to end in September 2014, Hati Kami conducted both endline surveys during a three-month period, June-August 2014.

ROLE OF PARTNERS

Local partners were integrally involved in the design and implementation of both baseline surveys, including the preparation of the evaluation instruments. Partners included the Municipality Health Office; the municipality government; administrative officials at the district, sub-district and community levels; and community leaders at the RW (community) and RT (sub-community) levels.

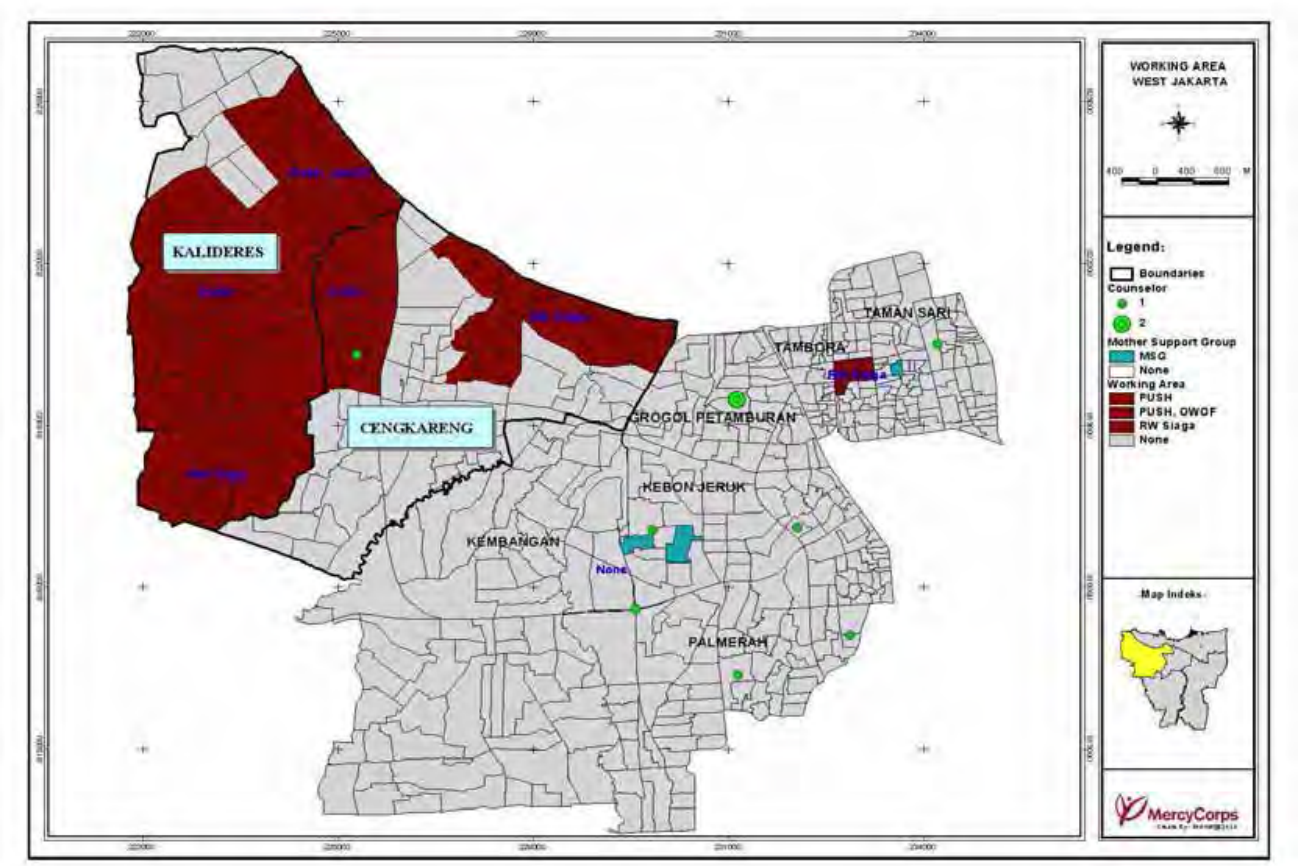
For the baseline surveys, Hati Kami obtained written permission from the provincial level on down. However, since the endline survey instruments and process were basically the same as those used for the baseline and the project is now well-known, Hati Kami simply requested verbal permission to conduct the endline surveys from officials at the municipal, district, sub-district, RW and RT levels. It is interesting to note that some of the partners such as the heads of certain PHCs and private midwives requested the endline survey results to use for their own planning purposes.

METHODS

As with the baseline, two population-based household surveys were used to measure the indicators. Household surveys sampled the following populations in the program intervention area: 1) mothers of children 0-23 months (CU2) for the **KPC Survey** and 2) pregnant women for the **Maternal Nutrition Survey**. These two groups of women and their children under 23 months were the key beneficiaries targeted by the program.

Population, Location of the Survey and Timing
The survey location was the Hati Kami intervention area in West Jakarta, specifically in eight sub-districts in Cengkareng and Kalideres Districts.

Figure 1: Map of Hati Kami Area Intervention



There are 505,178 people living in the intervention area and approximately 8,558 of them are pregnant women (1.71% of the total population) and 7,780 are mothers of children under 2. Table 1 describes the population size of the sub-districts in the intervention area. (Note: The following population figures are based on information available at the time of the two endline surveys. They are somewhat smaller than the figures reported in the final Evaluation Report, which was prepared later.)

Table 1: Population

District	Sub-district	Number of RW	TOTAL Population	Estimated Number of Pregnant Women	Estimated Number of Mothers of CU2
Cengkareng	Cengkareng Barat	16	66,847	1,132	1,029
	Cengkareng Timur	16	76,318	1,293	1,175
	Rawa Buaya	12	67,388	1,142	1,038
	Duri Kosambi	15	57,432	973	884
	Kedaung Kaliangke	8	18,293	310	282
	Kapuk	16	91,203	1,545	1,405
Kalideres	Kamal	10	40,497	686	624
	Tegal Alur	16	87,200	1,477	1,343
TOTAL		109	505,178	8,558	7,780

The Maternal Nutrition Survey was conducted from June 16 - July 21, 2014; it included two days of training and field testing and 20 days of data collection. The KPC Survey was conducted in July - August 2014 and included two days of training and field testing and 10 days of data collection.

Instruments

The questionnaires for both household surveys were designed to capture all key indicators, including the Rapid CATCH Indicators. These survey questionnaires were transformed into electronic forms. Using the DataDyne software, electronic data collection was used to interview the respondents in the field. The enumerators used their own android smartphones that had the electronic form installed. The data collected by enumerators was then uploaded into the DataDyne server. After the data collection process was completed, data in the server was downloaded and further analyzed using SPSS 17 Trial Version.

Sampling Design

The sample was taken from pregnant women and the mothers of CU2 who were living in Cengkareng and Kalideres Districts at the time the surveys were conducted. The cluster sampling technique was applied in the household surveys for the pregnant women population.

Cluster sampling is defined as probability sampling in which sampling units at some point in the selection process are collections, or clusters, of population elements (Kalton, 1983). The cluster unit in this survey was the community unit (*RW*). There were 109 RWs in the population area that were considered cluster units. At the first stage, the survey team selected the cluster from all cluster units in the population. A minimum of 30 clusters was randomly selected proportionate to population size (PPS) for both sample frames for each survey. However, since some clusters had a deficit number of pregnant women, additional clusters were selected to fulfill the entire sample size. In total, 39 clusters were selected during the Maternal Nutrition Survey.

In the second stage, the actual samples (pregnant women and mothers of CU2) were selected through a random selection process in the selected clusters. Since there was no pregnant women's list available in the selected clusters, the simple random sampling technique couldn't be applied. Instead, the random selection was done using the spin-the-pen technique to choose households in the selected cluster. If the selected household was eligible (pregnant woman was in the household), then the enumerator interviewed the woman. The next respondents were selected by intervals of 15 from the last interviewed household.

Sample Size

A. Maternal Nutrition

The sample size was calculated to measure 5-10% change from the baseline values of most program indicators. The formula used to estimate change differs from the formula used to estimate levels (FANTA, 1997), which was applied in the baseline survey.

$$n = \text{deff}\ \frac{((Z\alpha + Z\beta)^2 * (P1\,(1 - P1) + P2\,(1 - P2)) * r}{(P2 - P1)^2}$$

Where:

n = required minimum sample size;
deff = design effect, assumed to be 2 to compensate bias in cluster selection;
P^1 = the estimated baseline value;
P^2 = the expected/estimated endline value (defined in the program's target);
$(P^2 - P^1)$ = the magnitude of change desired/expected of an indicator;
Zα and Zβ = the z-score corresponding to the degree of confidence (α or β) with which it is desired to be able to conclude that an observed change of size (p2 - p1) would not have occurred by chance (statistical significance).
r = non-response rate (set to 5%).

α	Zα	β	Zβ
90.0%	1.282	80.0%	0.84
95.0%	1.645	90.0%	1.282
97.5%	1.96	95.0%	1.645
99.0%	2.326	97.5%	1.96
		99.9%	2.32

Since the survey population has finite population and the sample fraction is greater than 5%, the sample size was corrected using the following finite population correction formula (fpc).

$$Fpc = \frac{(N-n)}{(N-1)}$$

Where N is population size and n is required sample size.

Table 2: Statistical Breakdown

No	Indicator Name	CONFIDENCE LEVEL (α)	STATISTICAL POWER (β)	BASELINE ESTIMATE (P^1)	ENDLINE ESTIMATE (P^2)	SAMPLE SIZE	***SAMPLE SIZE + 5%***
1	% pregnant women who reported having increased portion of staple food during pregnancy	95%	80%	24%	34%	508	533
2	% pregnant women who reported taking an iron supplement yesterday	95%	80%	56%	67%	522	548
3	% pregnant women who reported taking folic acid tablet yesterday	95%	80%	62%	72%	547	574
4	% pregnant women who received counseling on breastfeeding or key maternal and infant care messages	95%	80%	4%	14%	208	218
5	% pregnant women who reported that iron tablet needs to be taken daily	95%	80%	66%	76%	508	533
6	% pregnant women who reported that folic acid supplement needs to be taken daily during pregnancy	95%	80%	50%	61%	535	562
7	% pregnant women who can	95%	80%	2%	7%	336	353

	name 3 messages on optimal nutrition during pregnancy						
8	% pregnant women who has accurate understanding of what exclusive breastfeeding for 6 months means	95%	80%	50%	61%	535	562
9	% pregnant women who has accurate understanding of early initiation of breastfeeding	95%	80%	1%	10%	154	162
10	% pregnant women who can name 6 dangers signs during pregnancy	95%	95%	0%	10%	209	219
11	% pregnant women who are registered in MSG	95%	95%	8%	18%	456	479
12	% pregnant women who recognize MSG as a resource for information on breastfeeding and maternal and infant care	95%	90%	15%	26%	491	516
13	% pregnant women who have MCH booklet	95%	80%	52%	63%	493	518

All of the calculation formulas described above were applied in the Mercy Corps Sample Calculator. The largest sample size was 547 plus 5% reserve, making the total sample 574, which was rounded to 575 samples. This sample size is enough to measure 5-10% changes of most of the maternal nutrition indicators.

B. KPC Survey (Mothers of CU2)

The KPC Survey was conducted using the Epi method. The sample size was the same as the baseline survey, which consisted of 300 mothers of children 0-23 months. A sampling procedure was utilized to select the 30 clusters (RW), and then the 300 mothers were selected from the clusters (10 per cluster). However, in this endline survey, a 10% reserve was added, increasing the total sample for the KPC Survey to 330 to anticipate errors in data collection. Over-sampling in order to obtain a sufficient sample size for the sub-group of mothers with infants 0-5 months was intentionally conducted and discussed during the training. During the data collection, as the team proceeded from one cluster to another, other random households were added until the total number of mothers of infants 0-5 months per cluster reached a total of at least five respondents. The over-sampling would not have been conducted if the cluster had already provided at least five or more respondents for the sub-group of mothers of infants 0-5 months.

The team: The team consisted of Mercy Corps' Health and Nutrition Program Manager (HNPM), Mercy Corps' M&E Specialist and enumerators. The M&E specialist led the process with support from the HNPM. Field-data collection was conducted by the enumerators who were trained and supervised by the M&E Specialist. Enumerators were public health students and anthropology students who had prior experience in health and nutrition surveys. Ten enumerators were hired for the Maternal Nutrition Survey and five enumerators were hired for the KPC Survey.

Training: The M&E Specialist conducted a t wo-day training for the enumerators, focusing on the survey topics and how to administer the questionnaires. Sessions included role play of interviews that helped the enumerators understand the survey topics and the questions. The enumerators were also trained to use the electronic data form instead of printed questionnaires. The training included field testing to allow the enumerators to practice delivering the interviews, become adept at the questions and at using the electronic data form; the field testing also provided an opportunity to test the applicability of the questionnaires.

Data collection: The average time for interviews was 40 minutes for the KPC Survey and 30 minutes for the Maternal Nutrition Survey. On average, each enumerator conducted 5-7 interviews per day for both surveys. It took 25 days to accomplish all the interviews for the Maternal Nutrition Survey and 15 days for the KPC Survey.

In terms of problems encountered during data collection, the completion of the KPC Survey data collection was hindered by the national holiday of Eid Mubarak. The data collection was delayed for one week since the majority of mothers of CU2 in the survey location were out of town. In the Maternal Nutrition Survey, it was difficult to find pregnant women in selected clusters. This consumed a lot of time for enumerators to find the pregnant women in the selected clusters.

For quality control, the enumerators were grouped in clusters to interview targeted respondents. In the first three interviews, M&E specialists observed the interview conducted by enumerators and discussed the interview session with the enumerators after the interview. The interview results in question were cross-checked among peer enumerators and re-checked by M&E specialists before the electronic forms were sent to the DataDyne server.

Data analysis: The data processing using electronic data collection consisted of the following steps:

1. The questionnaires were transferred into electronic data forms which were stored online in the DataDyne server.
2. Enumerator smartphones were installed with DataDyne software.
3. Enumerators downloaded the form from the server using the smartphones.
4. The enumerators directly recorded and stored the interview responses in the smartphones.
5. Once the results were clear (checked and verified), enumerators sent the data to the DataDyne server from their phones.
6. All completed questionnaires were stored in the Cloud/DataDyne servers.
7. The data was downloaded from the server in txt or excel format for further data processing and analysis.
8. Analysis was conducted offline using SPSS 17 Trial Version.

RESULTS

Table 3: Maternal Nutrition Indicators (Pregnant Women)

No	MATERNAL NUTRITION INDICATOR	ENDLINE RESULT				
		Numerator	Denominator	Proportion Estimate	Lower (p-)	Upper (p+)
1	% pregnant women who reported having increased portion of staple food during pregnancy	373	575	64.9%	59.4%	70.4%
2	% pregnant women who reported taking an iron supplement yesterday	387	575	67.3%	61.9%	72.7%
3	% pregnant women who reported taking folic acid tablet yesterday	468	575	81.4%	76.9%	85.9%
4	% pregnant women who received counseling on breastfeeding or key maternal and infant care messages	334	575	58.1%	52.4%	63.8%
5	% pregnant women with adequate food diversity	6.75			6.5%	6.9%
6	% pregnant women who reported that iron tablet needs to be taken daily	409	575	71.1%	65.9%	76.4%
7	% pregnant women who reported that folic acid supplement needs to be taken daily during pregnancy	336	575	58.4%	52.7%	64.1%
8	% pregnant women who can name 3 messages on optimal nutrition during pregnancy	72	575	12.5%	8.7%	16.3%
9	% pregnant women who have accurate understanding of what exclusive breastfeeding for 6 months means	292	575	50.8%	45.0%	56.6%
10	% pregnant women who have accurate understanding of early initiation of breastfeeding	31	575	5.4%	2.8%	8.0%
11	% pregnant women who have 70% knowledge on breastfeeding and maternal-newborn care	3	575	0.5%	-0.3%	1.4%
12	% pregnant women who can name 6 dangers signs during pregnancy	3	575	0.5%	-0.3%	1.4%
13	% pregnant women who are registered in MSG	49	575	8.5%	5.3%	11.7%
14	% pregnant women who recognize MSG as a resource for information on breastfeeding and maternal and infant care	14	575	2.4%	0.7%	4.2%
15	% pregnant women who have MCH booklet	446	575	77.6%	72.7%	82.4%

Table 4: KPC Indicators (Mothers of Children 0-23 Months)

No	KPC INDICATOR	ENDLINE				
		NUMERATOR	DENOMINATOR	Proportion Estimate	Lower (p-)	Upper (p+)
1	% children 0-23 months who were put on the breast within 1 hr. of birth	214	330	64.8%	57.6%	72.1%
2	% of children age 0-23 months who were put on the his/her mother breast and skin to skin immediately after birth until finished suckling or for at least 1 hour	134	330	40.6%	33.1%	48.1%
3	% children 0-5 months exclusively breastfed in the previous 24 hrs. (Rapid CATCH)	61	143	42.7%	31.2%	54.1%
4	Prelacteal feeding: % children aged 0-23 months **who received** a pre-lacteal feeding	78	330	23.6%	17.2%	30.1%
5	Prelacteal Feeds: Proportion of children younger than 24 months that **were not given pre-lacteal feeds** within the first 3 days after birth.	252	330	76.4%	69.9%	82.8%
6	% mothers who received AMTSL after birth of youngest child	144	330	43.6%	36.1%	51.2%
7	% mothers who received vitamin A within 6 weeks of the birth of their youngest child	151	330	45.8%	38.2%	53.4%
8	% of children 12-23 months who received DPT1 (Rapid CATCH)	59	99	59.6%	45.9%	73.3%
9	% mothers who received counseling on breastfeeding or maternal and infant care messages	263	330	79.7%	73.6%	85.8%
10	**Coverage of ORS use**: % of children 0-23 months with diarrhea who were given ORS and/or recommended home fluids (Rapid CATCH)	11	15	73.3%	41.7%	105.0%
11	**Coverage of treatment of Diarrhea with Zinc tablet**: % of children 0-23 months with diarrhea who were given zinc tablets	0	15	0.0%	0.0%	0.0%
12	% mothers of children 0 to 6 months who have MCH booklet	221	330	67.0%	59.8%	74.1%
13	Percentage of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the	221	330	67.0%	59.8%	74.1%

	birth of their youngest child (Rapid CATCH)					
14	Percentage of children age 0-23 months whose births were attended by skilled personnel (Rapid CATCH)	329	330	99.7%	98.9%	100.5%
15	Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall (Rapid CATCH)	109	187	58.3%	48.3%	68.3%
16	Percentage of children age 12-23 months who received a measles vaccination (Rapid CATCH)	90	99	90.9%	82.9%	98.9%
17	Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey (Rapid CATCH)	60	99	60.6%	47.0%	74.2%
18	Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider (Rapid CATCH)	56	98	57.1%	43.3%	71.0%
19	Percentage of households of children age 0-23 months that treat water effectively (Rapid CATCH)	210	330	63.6%	56.3%	71.0%
20	Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing (Rapid CATCH)	314	330	95.2%	91.9%	98.4%
21	Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population) (Rapid CATCH)	46	330	13.9%	8.7%	19.2%
22	Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices (Rapid CATCH)	50	187	26.7%	17.8%	35.7%
23	Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child (Rapid CATCH)	277	330	83.9%	78.3%	89.5%
24	Percentage of mothers of children age 0-23 months who are using a modem contraceptive method (Rapid CATCH)	238	330	72.1%	65.3%	79.0%
25	Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth (Rapid CATCH)	269	330	81.5%	75.6%	87.4%

DISCUSSION

A. Main Findings of Maternal Nutrition

Nutrition during Pregnancy

1. *Increased staple food consumption*: 64.9% (95% CI: 59.4% - 70.4%) of pregnant women in this endline survey reported that their staple food consumption increased during pregnancy. In the baseline 23.7% (95% CI: 19.5% - 27.9%) of pregnant women reported they increased consumption of staple food during pregnancy.

2. *Adequate food diversity*: the endline survey recorded that on average pregnant women eat 6.75 of 13 types of food. The baseline recorded an average 4.68.

Supplements for pregnancy

1. *Iron intake during pregnancy* increased to 67.3% (95% CI: 61.9%-72.7%) from a baseline of 56.4% (52.5%-61.3%). The increased coverage of iron supplement intake is significant. (p=0.000).

2. The baseline revealed that 66.3% (95% CI: 61.6%-71%) of pregnant women knew that they need to take an iron tablet once a day during the pregnancy. This coverage increased in the endline where 71.1% (95% CI: 65.9%-76.4%) of pregnant women reported knowing that iron tablets need to be consumed by pregnant women once a day. However, the increase in knowledge is not statistically significant (p=0.1801).

3. *Folic acid intake* increased from 62.1% (95% CI: 57.2%-66.9%) in the baseline to 81.4% (95% CI: 76.9%-85.9%). The increase is significant (p=0.000).

4. In the baseline the knowledge that a folic acid supplement needs to be taken daily was 50.3% (95% CI: 45.3%-55.2%). Endline records the increased coverage to 58.5% (95% CI: 52.7%-64.1%) and this increase is significant (p=0.0367).

Knowledge

1. Pregnant women who have an accurate *understanding of early initiation of breastfeeding* increased from 0.9% in the baseline to 5.4% (95% CI: 2.8%-8%) at endline.

2. Pregnant women who have an *accurate understanding of what exclusive breastfeeding for 6 months means* remains unchanged from the baseline. The baseline value for this indicator was 50.3% (95% CI: 45.3%-55.2%) and the endline is 50.8% (95% CI: 45%-56.8%). (p=0.8926)

3. Pregnant women who can name *3 messages on optimal nutrition during pregnancy* had a significant increase from 1.5% (95% CI: 0.3%-2.8%) in the baseline to 12.5% (95% CI: 8.7%-16.3%) at endline. However, there is no increase in a) pregnant women who have 70% knowledge on breastfeeding and maternal newborn care or b) understanding of danger signs during pregnancy. (Baseline 0%, endline 0.5%).

4. *MCH booklet*: at the baseline 51.9% (95% CI: 47-56.9%) of pregnant women had the MCH booklet. At endline 77.6% (95% CI: 72.7%-82.4%) of pregnant women have the MCH booklet.

5. There are no changes in *coverage of pregnant women who are registered in MSG*. The baseline revealed 7.7% of pregnant women were registered in MSG and at endline the number increased to 8.5%. The change is not statistically significant.

B. Main Findings of KPC Survey

Early Initiation of Breastfeeding

1. The percentage of children 0-23 months who were *put on the breast within 1 hour* of birth decreased from the baseline value. The baseline value was 70.7% (95% CI: 63.4%-78%) and the endline value is 64.5% (95% CI: 57.6%-72.1%). The coverage decreased but the change is not significant (p=0.2730).

2. The percentage of children age 0-23 months who were put on his/her mother's breast/had skin to skin contact immediately after birth increased. The baseline value was 27.3% (95% CI: 20.2%-34.5%) and the endline result is 40.6% (95% CI: 33.1%-48.1%). The change is significant at t= -0.251 and p=0.0146.

Breastfeeding and Exclusive Breastfeeding

1. *Exclusive breastfeeding*: the percentage children 0-5 months exclusively breastfed in the previous 24 hours (Rapid CATCH Indicator) increased from 23.4% (95% CI: 13.3%-33.3%) at baseline to 42.7% (95% CI: 31.2%-54.1%) at endline. The change is significant (p=0.0159).

2. *Pre-lacteal feeding*: the percentage of children age 0-23 months who received a pre-lacteal feeding decreased from 53% to 23.6%. This decrease is significant (p=0.000).

3. *Pre-lacteal feeds*: The proportion of children younger than 24 months that were <u>not</u> given pre-lacteal feeds within the first 3 days after birth increased from 47% to 76.4%, a change that is significant at p=0.000.

Immunization and Vitamin A

1. *DPT 1 coverage*: The percentage of children 12-23 months who received DPT1 (Rapid CATCH) increased to 59.6% (95% CI: 45.9%-73.3%) from 52.9% (95% CI: 37.9-67.9%). The increase is not significant (p=0.5226)

2. *Measles:* The percentage of children age 12-23 months who received a measles vaccination (Rapid CATCH) increased from 88.2% (95% CI: 78.5%-97.9%) to 90.9% (95% CI: 82.9%-98.9%). The increase is not significant (p=0.6777).

3. *DPT 3*: The percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey (Rapid CATCH) increased from 43.5% (95% CI: 28.6%-58.4%) to 60.6% (95% CI: 47%-74.2%). The increase is not significant (p=0.1008).

4. *TT vaccination*: The percentage of mothers with children age 0-23months who received at least two tetanus toxoid vaccinations before the birth of their youngest child (Rapid

CATCH) increased significantly from 8.7% (95% CI: 4.2%-13.2%) to 67% (95% CI: 59.8%-74.1%).

5. *Vitamin A for children 6-23 months*: The percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (card verified or mother's recall - Rapid CATCH) increased from 53% (95% CI: 42.3%-63.6%) to 58.3% (95% CI: 48.3%-68.3%). However, this increase of vitamin A coverage is not significant (p=0.4783).

6. *Vitamin A for mothers*: The percentage of mothers who received vitamin A within 6 weeks of the birth of their youngest child increased to 45.8% (95% CI: 38.2%-53.4%) from 29.3% (95% CI: 22%-36.6%). The increase is significant (p=0.0032).

Maternal and Newborn Care

1. *MCH booklet*: The percentage of mothers of children 0 to 6 months who had the MCH booklet increased from 54.3% (95% CI: 46.4%-62.3%) to 67.0% (95% CI: 59.8%-74.1%). The increase is significant at p=0.0235).

2. *Counseling*: The percentage mothers who received counseling on breastfeeding or maternal and infant care messages increased from 40.0% (95% CI: 32.2%-47.8%) to 79.7% (95% CI: 73.6%-85.8%). This increase is significant (p=0.000).

3. *ANC*: The percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child (Rapid CATCH) decreased from 91.3% (95% CI: 86.8%-95.8%) to 83.9% (95% CI: 78.3%-89.5%). However, the decrease is not significant (p=0.4269).

4. *Skilled delivery assisted*: The percentage of children age 0-23 months whose births were attended by skilled personnel (Rapid CATCH) increased from 98.7% (95% CI: 96.8%-100.5%) to 99.7% (95% CI: 98.9%-100.5%). But the increase is not significant (p=0.3199).

5. *AMTSL*: The percentage of mothers who received AMTSL after the birth of their youngest child increased from 30.0% (95% CI: 22.7%-37.3%) to 43.6% (95% CI: 36.1%-51.2%). The increase is significant (p=0.0135).

6. *Post-Natal Visit*: the percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth (Rapid CATCH) increased from 62.7% (95% CI: 54.9%-70.4%) to 81.5% (95% CI: 75.6%-87.4%). This increased coverage for post-natal visit is significant (p=0.0003).

Child Nutrition

1. *Infant and Young Child Feeding (IYCF)*: the percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices (Rapid CATCH) increased from 23.2% (95% CI: 14.2%-32.2%) to 26.7% (95% CI: 17.8%-35.7%). The increase is not significant (p=0.5886).

2. *Underweight*: The percentage of children 0-23 months who are underweight (-2 SD for the median weight for age according to the WHO/NCHS reference population (Rapid CATCH) decreased from 18.0% (95% CI: 11.9%-24.1%) to 13.9% (95% CI: 8.7%-19.2%). The decrease is not significant (p=0.3287).

Diarrhea and Pneumonia

1. *Coverage of ORS use*: The percentage of children with diarrhea who were given ORS and/or recommended home fluids (Rapid CATCH) increased from 40.4% (95% CI: 20.6%-60.3%) to 73.3% (41.7%-105.0%). This increase in ORS use is not significant (p=0.0883).

2. *Treatment of diarrhea with zinc tablet*: The percentage of children with diarrhea who were given zinc tablets decreased from 6.4% (95% CI:-3.5%-16.3%) to 0.0%.

3. The percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were *taken to an appropriate health provider* (Rapid CATCH) decreased from 85.7% (95% CI: 67.4%-104.0%) to 57.1% (95% CI: 43.3%-71.0%). The decrease is significant (p=0.0167)

Water and Handwashing

1. The percentage of households of children age 0-23 months that *treat water effectively* (Rapid CATCH) increased from 55.0% (95% CI: 47.0%-63.0%) to 63.6% (95% CI: 56.3%-71.0%). But the increase is not significant (p=0.1214)

2. The percentage of mothers of children age 0-23 months who live in households with *soap at the place for hand washing* (Rapid CATCH) increased from 73.3% (95% CI: 66.3%-80.4%) to 95.2% (95% CI: 91.9%-98.4%). This increase is significant.

ANNEX A: POPULATION DATA USED FOR CLUSTER SAMPLING

Table 1: Population in the Survey Location

District	Sub District	Number of RW	TOTAL Population	Estimated Number of Pregnant Women	Estimated Number of Lactating Women
Cengkareng	Cengkareng Barat	16	66,847	1,132	1,029
	Cengkareng Timur	16	76,318	1,293	1,175
	Rawa Buaya	12	67,388	1,142	1,038
	Duri Kosambi	15	57,432	973	884
	Kedaung Kaliangke	8	18,293	310	282
	Kapuk	16	91,203	1,545	1,405
Kalideres	Kamal	10	40,497	686	624
	Tegal Alur	16	87,200	1,477	1,343
TOTAL		109	505,178	8,558	7,780

Table 2: Selected Clusters for KPC Survey

Kelurahan	Selected RW / Cluster	Population
Cengkareng Barat	RW 3	5,365
	RW 6	4,021
	RW 9	4,607
	RW 14	2,087
Cengkareng Timur	RW 3	5,080
	RW 6	4,778
	RW 10	4,454
	RW 13	4,477
Rawa Buaya	RW 1	9,928
	RW 2	11,378
	RW 4	14,670
	RW 11	8,982
Duri Kosambi	RW 1	7,674
	RW 4	4,597
	RW 6	5,148
Kedaung Kaliangke	RW 1	1,836
	RW 8	2,231
Kapuk	RW 3	6,168
	RW 6	4,757
	RW 9	6,019
	RW 12	6,765
	RW 16	7,068
Kamal	RW 2	4,518
	RW 6	3,374
Tegal Alur	RW 1	6,178
	RW 3	6,963
	RW 6	5,966
	RW 8	6,993
	RW 11	5,734
	RW 13	5,454
TOTAL	30	177,270

Table 3: Selected Clusters for Maternal Nutrition Survey

Sub District	Selected RW/cluster	Estimated Total Number of Pregnant Women
Cengkareng Barat	RW 3	91
	RW 6	68
	RW 9	78
Cengkareng Timur	RW 1	89
	RW 4	86
	RW 7	86
	RW 10	75
	RW 14	70
Rawa Buaya	RW 1	168
	RW 2	193
	RW 4	249
	RW 11	152
Duri Kosambi	RW 1	130
	RW 4	78
	RW 7	58
Kedaung Kaliangke	RW 3	66
Kapuk	RW 1	84
	RW 4	72
	RW 7	106
	RW 9	102
	RW 12	115
	RW 16	120
Kamal	RW 3	92
	RW 7	78
Tegal Alur	RW 1	105
	RW 3	118
	RW 6	101
	RW 9	113
	RW 11	97
	RW 15	61
TOTAL	30	3101

ANNEX B: TRAINING FOR SUPERVISORS AND ENUMERATORS

A. Training and Data Collection Schedule

1. Maternal Nutrition (June 21, 2014 – July 14, 2014)
   - 2 days' training and field test
     - June 18 – June 20, 2014
   - 25 days of data collection

2. Infant and Young Child Health & Feeding (July 23, 2014 – July 25 2014 and August 12 - August 23, 2014)
   - 2 days' training and field test
     - July 20 – July 22, 2014
   - 3 days data collection; break for Eid Mubarak Holidays; then started again on August 12, 2014 until August 23, 2014

B. Illustrative Program

Day 1	
8.00 - 8.30	Introduction: Hati Kami, Mercy Corps Indonesia
8.30 - 9.30	Endline Survey (Indicators, baseline values, target)
9.30 - 9.45	Coffee Break
9.45 - 11.00	Sampling (cluster, how to find respondent)
11.00 - 12,00	Questionnaires (introduction to questionnaire, review, discussion and electronic form installation)
12.00 – 13.00	Break: Lunch
13.00 - 14.00	Interview technique, avoiding bias in interview (review, role play and discuss)
14.00 - 15.00	Role play (continue)
15.00 - 15.15	Coffee Break
15.15 - 16.30	Data collection procedure, quality check
16.30 - 17.00	Plan for field test
Day 2: Field test	
09.00	Team arrives in the field location
9.00 - 12.30	Practicing:
	Finding respondents
	Interview using electronic form
	Questionnaire quality check, sending the interview result
12.30 - 13.15	Break
13.15 - 14.15	Feed-back and discussion
14.15 - 15.30	Plan and schedule for data collection, assigned clusters etc.
16.00	Team leaves field location

ANNEX C: BUDGET FOR ENDLINE SURVEYS (in Indonesian Rupees)

KPC Survey

No.	**Activities**	**Time**	**Quantity**	**Price**	**Cost**
1	Enumerator Training	2	7	30,000	420,000
2	Phone vouchers for enumerators	1	4	100,000	400,000
3	Gift for respondent*	1	330	5,000	1,650,000
4	Questionnaire Fee**	1	330	75,000	24,750,000
5	Transportation	14	1	500,000	7,000,000
Total					34,220,000

**There was no pre-notification of the gift (soap) to avoid bias. The gift will only be shown once the interview is completed*
***Enumerators are paid based on their completion of the interviews*

Maternal Nutrition Survey

No.	**Activities**	**Time**	**Quantity**	**Price**	**Cost**
1	Enumerator Training	2	7	30,000	420,000
2	Phone Vouchers for enumerators	1	7	100,000	700,000
3	Gift for respondent*	1	576	5,000	2,880,000
4	Questionnaire Fee**	1	576	75,000	43,200,000
5	Transportation	14	1	500,000	7,000,000
Total					54,200,000

ANNEX D: SURVEY INSTRUMENTS

1. Maternal Nutrition (Pregnant Women):

QUES NO. | | | | | | |

QUESTIONNAIRE FOR
MATERNAL NUTRITION – HATI KAMI

1. ENUMERATOR: _____

2	DISTRICT: 1. Cengkareng 2. Kalideres		
3	SUBDISTRICT: 1. Cengkareng Barat 2. Cengkareng Timur 3. Rawa Buaya 4. Duri Kosambi 5. Kedaung Kaliangke 6. Kapuk 7. Kamal 8. Tegal Alur		
4	RW : _____	5. RT :_____	6. HOUSE NUMBER: _____
7	DATE OF INTERVIEW		
8	NUMBER OF PREGNANT WOMEN IN THE HOUSE		
9	SURVEY RESULT : 1. Complete 2. Partially complete 3. Refused to take the survey		

SECTION 1: BACKGROUND

10	NAME OF RESPONDENT		
11	RESPONDENT AGE (years)		DATE OF BIRTH : _____
12	DOB VERIFICATION SOURCE : 1. any legal ID card 2. verbal only (assuring) 3. respondent unsure		
13	MARRIAGE STATUS: 0. Not married 3. Divorced 1. Married 4. Widow		
14	RESPONDENTS EDUCATION : 00. Never gone to formal school 01-05. Grade 1-5 06. Graduated elementary school 07-08. Junior high grade 1-2 09. Graduated junior high 10–11. High school grade 1-2 12. Graduated high school 13. University (S1) graduate 14. More than S1 99. Do not know		

15	Total Biological Children (born alive before this pregnancy) :		
16	What stage of pregnancy are you in? (in week) 1. 1 – 12 weeks 2. 13 – 27 weeks 3. 28 – 42 weeks 4. Other : ____ weeks		
17	Pregnancy age verification source?	1 = KIA booklet/ any ANC visit card=1, 2 = according to respondent 3 = respondent not so sure	

SECTION 2: MATERNAL NUTRITION

NO	QUESTION	CODE
18	Have you experienced any difficulty seeing in daytime? 0. No **(skip to no 20)** 1. Yes **(skip to no 19)** 2. Cannot remember **(skip to no 20)** 9. Not sure/ do not know **(skip to no 20)**	
19	**If 18 is Yes**, is this problem still occuring yesterday? 0. No 1. Yes 8. Not applicable (no dusk blindness/ 18 is No 9. Do not know/ cannot remember	
20	During this pregnancy, have you had any difficulty seeing at dusk, for example bumping into furniture when walking around the house? 0. No 1. Yes 2. Cannot remember 9. Not sure/ do not know	
21	During this pregnancy, do you take any supplements that contain iron? (probing with example if need be and ask respondent to show iron supplement) 0. No (**SKIP TO NO. 26)** 1. Yes and can show iron supplement owned 2. Yes but cannot show sample of iron supplement owned 3. Cannot remember (**SKIP TO NO. 26)** 9. Not sure/do not know (**SKIP TO NO. 26)**	
22	Did you take an iron supplement yesterday? 0. No 1. Yes, in the morning 2. Yes, inthe day or after 3. Yes, in the evening 4. Yes, more than once a day 5. Cannot remember	
23	How often do you take the iron supplements? 1. Once a day, everyday 2. Once a week 3. When I remember, sometimes I forgot	

	4. Other: _____		
24	From whom did you recieve the iron supplement/ tablet? **(more than one answer can be accepted)** **Code 1 = Yes, 0 = No**		
	a. Private midwife	0 1	
	b. Midwife at Puskesmas	0 1	
	c. Private obstetrician	0 1	
	d. MD/ obstetrician at Puskesmas	0 1	
	e. I bought them at my own initiative	0 1	
	f. My family gave them to me	0 1	
	g. Other?	0 1	
25	How many of the iron supplement have you taken since you became pregnant?		
	0. None 1. Less than 10 2. 10-20 3. 21-30 4. 31-40 5. 41-50 6. 51-60 7. 61-70 8. 70-80 9. 81-90 10. More than 90 = 10 11. Did not count/ do not remember how many		
26	Have you taken any folic acid vitamin? (probe with sample guides) 0. No **(skip to no 31)** 1. Yes, as separate preparation from iron **(skip to no 27)** 2. Yes, my supplement has both iron and folic acid **(skip to no 31)** 8. I do not know if my supplement has it/ do not care. The supplement has both iron and folic acid **(skip to no. 31)** 9. I do not know if my supplement has it/ do not care. The folic acid supplement is separated preparation from iron **(skip to no 27)**		
27	If separate table/ preparation from iron, did you take the folic acid vitamin yesterday? If yes, when exactly?		
	0. No 1. Yes, in the morning 2. Yes, in the day or afternoon 3. Yes, in the evening 4. Yes, more than once a day 9. Cannot remember		
28	If separate from iron supplement, how often do you take it?		
	1. Once a day, everyday 2. Once a week 3. When I remember/ sometimes I forgot 4. Other :_____		
29	From whom did you receive the folic acid vitamins from? (**MORE THAN ONE ANSWER CAN BE ACCEPTED, DO NOT READ THE ANSWERS) CODE 1=Yes, 0=No**		

	a. Private midwife	0 1	
	b. Midwife at Puskesmas	0 1	
	c. Private obstetrician	0 1	
	d. MD/ obstetrician at Puskesmas	0 1	
	e. I bought them at my own initiative	0 1	
	f. My family gave them to me	0 1	
	g. Other?_____	0 1	
30	How many of the folic acid vitamin have you taken? **Answers Code**: XYZ = List mentioned the amount in 3 digits; 0 = None ; 8 = Cannot remember; 9 = Do not know		
31	How many times did you eat yesterday? How many times did you eat yesterday? 0 = Not at all 1-3. As mentioned by respondent 4 = 4 times 5 = 5 times 6 = too often/ am always hungry 9 = Do not know/ cannot remember		
32	Usually, how do you get your meals? 1. Self cook 2. Cook by others 3. Buy food ready served		
33	Do you eat more frequently compared to when you were not pregnant? 0. No 1. Yes I have 1 extra meal/snack 2. Yes, I have 2 extra meals/snacks 3. Yes, very often/ more than 3 extra meal/snacks) 9. Do not know/ cannot remember		
34	Did you have larger portion everytime you eat compared to when you were not pregnant? 0. No, just the same 1. Less 2. More 9. Not sure/ do not know		
35	Do you usually drink any tea/coffee after eating your meals? **(More than one answer is acceptable**) **CODE 0 = No, 1 = Yes**		
	a. Black tea with sugar	0 1	
	b. Black tea without sugar	0 1	
	c. Black coffee (without sugar)	0 1	
	d. Coffee with sugar	0 1	
	e. Other caffeine?	0 1	

SECTION 3: DIETARY DIVERSITY

36. Ask if she has had any of the following yesterday(last 24 hours) at any time and how many times.

DIETARY IN SCALE OF TIME	NOTES
Last Night meal	
Night snack until morning	
Breakfast	
Snack between breakfast until Lunch	
Lunch	
Snack after lunch	

Each meal should be probe into the ingredients of these groups below

LIST OF FOOD INGREDIENTS
Code: None=0, One time=1, Two times=2, Three times=3, Four times or more = 4

1. Rice, bread, noodles, corn, thick congee	
2. Roots: Potato, Cassava, Taro root, Sukun	
3. Pumpkin, carrot, yellow/orange yams/ sweet potato	
4. Green vegetables (broccoli, etc.)	
5. Other vegetables (cauliflower,etc.)	
6. Ripe mango, papaya, banana (orange/yellow fruit)	

7. Other Fruits (tomato, melon, watermelon, etc)	
8. Intestines, liver, etc	
9. Red meat	
10. White meat	
11. Fish and seafood	
12. Nuts, legumes, soyabeans	
13. Eggs	
14. Dairy and Dairy product	
15. Any kinds of Oil, degenerated/ animal fat, coconut milk, margarine	

SECTION 4: ANTENTAL CARE

37	Have you had an antenatal care visit? 0. No (**skip to no. 42**) 1. Yes		
38	If yes, where is **the last visit** did you go for ANC? If yes, where is the last visit did you go for ANC? **(ONLY ONE ANSWER)** 1 = Puskesmas 2 = Private practice/clinic of midwife 3 = Obstetrician clinic 4 = Hospital 5 = House 8 = NA (never had ANC) 9 = do not know/ cannot remember		
39	What was the reason to have your ANC there (no. 38)? **(OPTIONS OF ANWERS CANNOT BE SPOKEN, CAN BE MORE ONE ANSWER) CODE 0 = No, 1 = Yes**		
	a. Close distance from house	0 1	
	b. Affordable: Rp. ...../ ANC	0 1	

	c. Friendly service	0 1	
	d. Recommended by close relative	0 1	
	e. Had previous delivery there	0 1	
	f. The place is good	0 1	
	g. I can have early initiation of breastfeeding	0 1	
	h. The place do not use formula milk	0 1	
	i. Covered by my health insurance	0 1	
	j. Other, namely_____	0 1	
40	**If 37 is Yes**, how many antenatal visits have you had during your pregnancy? 1-4 = as mentioned by respondent 5 = Five times or more 8 = NA (never had ANC) 9 = do not know/ cannot remember		
41	**If 37 is Yes**, Who conducted your **last ANC visit**? **(ONLY ONE ANSWER)** 1. TBA/ Dukun 2. Midwife in puskesmas 3. Private midwife 4. Clinic obstetrician 5. General practitioner 6. Others : _____ 8. NA (never had ANC) 9. Not sure/do not know		
42	**If 37 is No**, what is the main reason? **(MORE THAN ONE ANSWER IS ACCEPTABLE, DO NOT READ THE OPTIONS)**		
	1. It must be expensive/ cannot afford it 2. to far 3. bad service 4. do not think it is necessary 5. there is no medical officer anyway 6. others:_____ 8. NA (had ANC) 9. do not know/ cannot remember	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	
43	The last time you had ANC, was one of the following done at least once? **(OPTIONS MUST BE READ)** Code: 0 = No 1 = Yes 2 = Cannot remember 9 = Not sure/ do not know		
a.	Weighed	0 1 2 9	
b.	Blood pressure check	0 1 2 9	
c.	Belly palpation or measurement	0 1 2 9	
d.	Blood was drawn from my finger tips/ with syringe	0 1 2 9	

e.	Baby's heart beat was listened to	0 1 2 9	
f.	Height measured	0 1 2 9	
44	The last time you had an ANC visit, what information did you receive? **(OPTIONS MUST BE READ)** Code: 0 = No 1 = Yes 2 = Cannot remember 9 = Not sure/ do not know		
a.	Delivery due date	0 1 2 9	
b.	Advice on nutritious diet	0 1 2 9	
c.	Early initiation of breastfeeding	0 1 2 9	
d.	Iron tablet supplement	0 1 2 9	
e.	Folic acid supplement	0 1 2 9	
f.	Danger signs during pregnancy	0 1 2 9	
g.	Signs of labor	0 1 2 9	
h.	Schedule for the next ANC	0 1 2 9	
i.	Other : _____	0 1 2 9	

SECTION 5: KNOWLEDGE & AWARENESS

45	Where/who did you get information on healthcare and nutrition for pregnant women? **(DO NOT MENTION ANSWER, JUST PROBE FROM WHOM OR WHERE)** No = 0, Yes = 1		
A.	My mother	0 1	
B.	Mother in Law	0 1	
C.	Husband	0 1	
D.	Other family member	0 1	
E.	Neighbor	0 1	
F.	Assistant/Kader	0 1	
G.	Other health workers/officers	0 1	
H.	Quran/ Bibble study group	0 1	
I.	TV advertisement/ show	0 1	
J.	Poster, billboard	0 1	
K.	Mothers Support Group	0 1	
L.	Puskesmas/ Hospital	0 1	
M.	Practice of Doctor/ midwife	0 1	
	Other: _____	0 1	
46	**To your knowledge**, how often should iron tablet be taken for your pregnancy?		
	1. Once a day, everyday 9. Do not know 2. Once a week 4. Others_____		
47	**To your knowledge**, how often should you take folic acid vitamin?		

	1. Once a day, everyday 9. Do not know 2. Once a week 4. Others_____		
48	What messages have you heard about infant and/or child feeding? **(DO NOT TELL THE ANSWERS, just ask: "What else?")** **Code**: None = 0 Yes = 1 **(MORE THAN ONE ANSWER IS ACCEPTABLE)**		
	a. Put newborn to mother's chest/ tummy right away after birth	0 1	
	b. Immediately allow baby to breastfeed right after birth	0 1	
	c. Colostrum should be given to baby/ do not throw it away	0 1	
	d. Feed only breastmilk for the first 6 months	0 1	
	e. Feed until one breast is empty before feeding with the other breast	0 1	
	f. Correct positioning and latch on	0 1	
	g. Benefit of breastfeeding/ breastmilk	0 1	
	h. Breastfeed/ give breastmilk on demand	0 1	
	i. Continue to breastfeed when baby is sick	0 1	
	j. Anything about breastmilk expression. Pumping	0 1	
	k. Continued breastfeeding until the child is ≥ 2 years old	0 1	
	l. Start complementary feeding at 6 months	0 1	
	m. Nutritious complementary food	0 1	
	p. Mothers Support Group can help peer mother	0 1	
	q. Others, namely _____	0 1	
49	Can you name **key dietary practices during pregnancy**? **(MORE THAN ONE ANSWER IS ACCEPTABLE, DO NOT READ THE ANSWERS)**		
	a. Pregnant women should eat variety of animal protein, fruit and vegetable	0 1	
	b. Red, yellow and orange color fruits are very good to be consumed during pregnancy	0 1	
	c. IPregnant women should eat more than before pregnancy	0 1	
	d. Other :	0 1	
50	Do you know what are considered danger signs during pregnancy? **(DO NOT READ THE ANSWERS)** **Code:** None= 0 Yes= 1 **(MORE THAN ONE ANSWER IS ACCEPTABLE)**		
	a. Bleeding per vagina	0 1	
	b.Swollen feet, hand, face, accompanied with headache	0 1	
	c. High fever	0 1	
	d. Leaking water sac before due week	0 1	
	e. Decreasing fetal movement (>6 months pregnant)	0 1	
	f. Heavy vomiting	0 1	
51	Is there any support group for mothers in your neighborhood? 0. No 1. Yes 9. Do not know		
52	Did you ever join the Mothers Support Group? 0. No 1. Yes		
53	Do you have any KIA (MCH) booklet? **Verify: ask to see it!** 0 . No, never had it for this pregnancy 1. Yes and can show it 3. Yes but missing 4. Yes but it is with the midwife		

SECTION 6: GENERAL FOOD SECURITY QUESTIONS

54	In the past 4 weeks did you or any member of your household have to **eat a limited variety of food** due to lack of resources? 0. No (variation increased) 1. Yes 3. Cannot remember 4. Just the same (no changes)	
55	In the past 4 weeks did you or any member of your household **eat smaller meals** than you felt you needed because there was not enough food? 0. No (food portions increased) 1. Yes 3. Cannot remember 4. Just the same	
56	In the past 4 weeks did you or any member of your household **eat fewer meals in a day** because there was not enough food? 0. No (eat more frequently) 1. Yes 3. Cannot remember 4. Just the same	
57	In the past 4 weeks did you or any member of your household go for **a whole day or night w/out** eating anything because there was not enough food? 0. No 1. Yes 3. Cannot remember 4. Just the same	
58	In the past 4 weeks did you worry that your **household would not have enough food**? 0. No (more than enough) **(end)** 1. Yes **(skip to no. 59)** 3. Cannot remember **(end)** 4. Just the same **(end)**	
59	If the **No. 58 is Yes**, Do you have this same worry for the foreseeable future? 0. No 1. Yes 3. Cannot remember 4. Just the same	

EXAMINATION OF INTERVIEW RESULT		
Questionnaire checked by		Date : ___/____/____Signature :
Field Supervisor		
Data Entry Person		Date : ___/____/____Signature :

2. KPC (Mothers of Children 0-23 Months):

☐ OVER SAMPLE (0-6 Month)

Interview code: |___| |___| |___|___| |___| |___|___|

Kec Kel RW Enum

No Resp

HATI KAMI KPC SURVEY

Tanyakan kepada Ibu apakah ia mempunyai anak di bawah 24 bulan yang tinggal bersamanya. Jika ya, lanjutkan wawancara, jika tidak ucapkan terima kasih kepada ibu dan akhiri wawancara.

Ask the mother if she has children under 24 months who lived with him. If yes, continue the interview, if not thank to mother and end interview

INFORMED CONSENT

Selamat siang/sore. Nama saya_____, dan sedang bekerja dengan Mercy Corps dan Suku Dinas Kesehatan Jakarta Barat. Kami sedang melakukan survey rumah tangga. Kami akan menanyakan tentang kesehatan ibu dan kesehatan anak termuda ibu yang berumur kurang dari dua tahun. Informasi ini akan membantu pemerintah dalam merencanakan pelayanan kesehatan. Wawancara akan berlangsung sekitar 30 menit. Informasi yang ibu berikan akan dijaga kerahasiaannya dan tidak akan ditunjukkan kepada orang lain.

Good afternoon / evening. My name_____ and I am working with Mercy Corps and Municipality of Health Office Department of West Jakarta. We are conducting a survey of households. We will inquire about the health of mothers and the health of your youngest child aged less than two years. This information will assist the government in planning health services. Interviews will last approximately 30minutes. The information that mothers provide will be kept confidential and will not be shown to others.

Partisipasi di dalam survei ini bersifat sukarela dan ibu dapat menolak untuk menjawab pertanyaan atau tidak melanjutkan wawancara. Kami berharap ibu dapat berpartisipasi karena pendapat ibu sangat penting.

Participation in these surveys is voluntary and you can refuse to answerquestions or do not continue the interview. We hope she can participate because themother is very important opinion.

Saat ini, apakah Ibu bersedia berpartisipasi dalam survei ini? Apakah saya dapat memulai wawancara ini?

Now, whether your are willing to participate in this survey? Can I start this interview?

Tandatangan pewawancara: _____ Tanggal: _____

Signature of interviewer: _____ Date:_____

RESPONDEN SETUJU UNTUK DIWAWANCARA.....1
RESPONDENT AGREES TO interviewed

RESPONDEN TIDAK SETUJU UNTUK DIWAWANCARA.....2 ☐ SELESAI
RESPONDNET DOES NOT AGREE TO INTERVIEWED

IDENTITAS RUMAH TANGGA HOUSEHOLD IDENTITY		**CODE**
Kecamatan *District*		
Kelurahan *Sub-District*		
RT/RW		

Nomor Rumah *House Number*		
Nomor Urut Rumah Tangga *Household Number*		
Nama Responden *Name of Respondent*		
Kepemilikan kartu GAKIN *Belonging of Poor Family Card*	1. Ya *Yes* 2. Tidak *No*	

IDENTITAS WAWANCARA INTERVIEW IDENTITY					
	1	2	3	Final Visit	
Tanggal wawancara *Date of Interview*	___/____/____ Tgl/ bln / thn	___/___/____ Tgl/ bln / thn	___/___/____ Tgl/ bln / thn	*Untuk Supervisor* Tanggal	
Nama pewawancara *Name of Interviewer*				Bulan	
				Tahun	
Waktu wawancara *Interview Time*	____s/d_____	____s/d____	____s/d____		
*Result Code**	[ ]	[ ]	[ ]	*Result Code*	

* *Result Codes*:
1. Lengkap *Complete*
2. Responden tidak di rumah *Respondent not in her home*
3. Ditunda *Pending*
4. Menolak *Refuse*
5. Lainnya, Sebutkan *Other,*_____

PEMERIKSAAN HASIL WAWANCARA INTERVIEW RESULT CHECKS		
Nama Pengecek kuesioner *Name of Questionnaire talker*		Tanggal *Date* : ___/____/____
Nama Supervisor *Name of Supervisor*		
Data dientri oleh Data entry by		Tanggal *Date* : ___/____/____ Tgl/bulan/tahun Day/Month/Year

Target dari kuesioner ini adalah ibu dari anak umur kurang dari 24 bulan

The target of this questionnaire is the mother of children aged less than 24 months

NO.	PERTANYAAN DAN SARINGAN	KATEGORI KODE	SKIP
A. KARAKTERISTIK DAN KESEJAHTERAAN SOSIAL/EKONOMI			
1	Pada bulan dan tahun berapakah ibu dilahirkan? (CATAT PADA KODE 1) *What month and year did you gave birth ?* BILA IBU MENJAWAB TIDAK TAHU TANYAKAN BERAPA UMUR IBU SEKARANG, KEMUDIAN CATAT DI KOLOM UMUR	1. Tanggal Lahir |___.___|___.___|___.___.___.___| 2. Umur ibu |___.___| Tidak Tahu : 98	
2	Apa pendidikan terakhir ibu? *What is your educational level ?* JAWABAN HANYA SATU ; PILIHAN JAWABAN JANGAN DIBACAKAN	Tidak sekolah *no school* .....1 Tidak tamat SD *not complete elementary school*.....2 Tamat SD *graduate elementary school*.....3 Tidak tamat SLTP *not complete junior high school*.....4 Tamat SLTP *graduate junior high school*.....5	

		Tidak tamat SLTA *not complete senior high school*.....6 Tamat SLTA *graduate senior high school*.....7 Tidak tamat Akad/PT *not complete college*.....8 Tamat Akademi/PT *complete college*.....9	
3	Berapa perngeluaran Ibu untuk keperluan rumah tangga dan keluarga setiap bulan? *How much do you spend for household needs every month?*		
	TANYA PENGELUARANNYA UNTUK APA SAJA? MINTA IBU MENGHITUNG PENGELUARAN SELAMA 1 MINGGU, KEMUDIAN DITAMBAH DENGAN PENGELUARAN RUTIN BULANAN DAN MINTA IBU UNTUK MENGKALKULASI	< 500,000.....1 500-1,000,000.....2 1,000,000-1,500,000.....3 1,500,000-2,000,000.....4 > 2,000,000.....5	
4	Apakah ibu memiliki dan menggunakan HP sendiri? *Do you have or use mobile phone by your self?* PASTIKAN SEHARI HARI DIPAKAI DAN DIBAWA OLEH IBU, BUKAN OLEH SUAMI / ANAK	*Ya* *Yes*.....1 Tidak *No*.....2	☐6.A
5	Rata-rata, berapa banyak dana yang digunakan untuk membayar tagihan atau membeli pulsa untuk SMS maupun telpon dalam sebulan? *On the average, how much do you spend for call or send text a month?*	< 10,000.....1 10,000-25,000.....2 26,000-50,000.....3 51,000-100,000.....4 >100,000.....5	
6.A	Jika ada pelayanan informasi kesehatan ibu dan anak melalui sms, yang dimana Ibu bisa mengirimkan pertanyaan mengenai kesehatan ibu dan anak, serta mendapatkan jawabannya melalui sms, apakah Ibu tertarik untuk mendaftar? *If there any information service about Maernal and Child via text which you can send question and get the answer do you interest to register?*	Ya *Yes*.....1 Tidak *No*.....2	☐7
6.B	Jika pelayanan sms centre kesehatan tersebut harus dibayar seharga Rp. 2000/sms, apakah ibu bersedia membayar? *If the text center should be paid 2000/text you have willingness to pay?*	Ya *Yes*.....1 Tidak *No*.....2	☐7
6.C	Jika pelayanan sms centre kesehatan tersebut harus dibayar seharga antara Rp. 1000-2000/sms, apakah ibu bersedia membayar? *If the text center should be paid 1000-2000/text you have willingness to pay?*	Ya *Yes*.....1 Tidak *No* 2	☐7
6.D	Jika pelayanan sms centre kesehatan tersebut harus dibayar seharga antara Rp. 500-1000sms, apakah ibu bersedia membayar? *If the text center should be paid 500-1000/text you have willingness to pay?*	Ya *Yes*.....1 Tidak *No* 2	☐7
6.E	Jika pelayanan sms centre kesehatan tersebut harus dibayar seharga antara Rp. 150-500/sms, apakah ibu bersedia membayar? *If the text center should be paid 150-500/text you have willingness to pay?*	Ya *Yes*.....1 Tidak *No*.....2	
7	Apakah Ibu menggunakan jejaring sosial seperti : BACAKAN PILIHAN JAWABAN; JAWABAN BOLEH LEBIH DARI SATU *Do you use the social network like....*		

	A. Facebook..... B. Twitter ..... C. Friendster..... D. Kaskus..... E. Multiply ..... F. My space..... G. Yahoo Koprol ..... H. Lainnya *other*, Sebutkan *mention*_____ I. Tidak Menggunakan sama sekali *do not use*	YA TIDAK A..... 1 ..... 0 B..... 1 ..... 0 C..... 1 ..... 0 D..... 1 ..... 0 E..... 1 ..... 0 F..... 1 ..... 0 G..... 1 ..... 0 H..... 1 ..... 0 I. 1 0	☐8
7.A	Dimana dan dengan apa Ibu mengakses jejaring sosial tersebut? JANGAN BACAKAN JAWABAN *Where and What with do you access those social network?*		
	A. Handphone..... B. Komputer & jaringan internet pribadi di rumah *computer & internet network in home*..... C. Handphone, Komputer & jaringan internet teman/keluarga *handphone, computer & friend or family internet network* ..... D. Komputer di warnet *computer on cafe*..... E. Komputer & jaringan internet di kantor *computer and internet network in office*..... F. Lainnya *other*, sebutkan *mention*_____	YA TIDAK A..... 1 ..... 0 B..... 1 ..... 0 C.....1 ..... 0 D. .....1 ..... 0 E. .....1 ..... 0 F. 1 0	
7.B	Seberapa sering Ibu menggunakan jejaring sosial tersebut? *How many ofter do you use these social network?*	Setiap hari *Every day*.....1 2x/week.....2 1x/week.....3 1x/2 week.....4 1x/ month.....5 Lainnya *other*, sebutkan *mention* _____6	

B. HEALTH CONTACTS AND SOURCES OF HEALTH INFORMATION

8	Selama bulan lalu berapa sering Ibu datang dan bertemu dengan petugas berikut ini: *During the last month how many often you came and got contact with this staff:* BACAKAN PILIHAN JAWABAN DAN LINGKARI YG SESUAI	RUTIN (4 kali atau lebih) *Routine (4 time or more)*	Kadang kadang (1-3 kali) *Sometime (1-3 times)*	Tidak Pernah *Never*	
	A. Dokter *Doctor* B. Perawat/Bidan *Nurse/Midwife* C. Tenaga Kesehatan Lain *Another health worker* D. Kader *Community health worker* E. Lainnya *Other*, Sebutkan *Mention*_____	1 1 1 1 1	2 2 2 2 2	3 3 3 3 3	
9	Dari manakah Ibu mendapat informasi atau saran tentang kesehatan dan gizi? *From whom do you get the information or suggestion about health and nutrition ?* JANGAN BACAKAN PILIHAN JAWABAN; JAWABAN BOLEH LEBIH DARI 1; CATAT SEMUA JAWABAN				
	A. Dokter *Doctor*..... B. Perawat/Bidan *Nurse/Midwife*..... C. Kader *Cadre*..... D. Suami/pasangan *Husband/Partner*.....	YA *YES* TIDAK *NO* A. .....1.....2..... B. .....1.....2..... C. .....1.....2..... D. .....1.....2.....			

	E. Orang Tua/Kakek/nenek *Parent/Grand Father/Grand Mother*... F. Keluarga *Family*..... G. Teman/tetangga *Friend / Neighboor*..... H. Bidan Di Desa *Midwife in Village* ..... I. Lainnya *Other*, Sebutkan *Mention*_____	E. .....1.....2..... F. .....1.....2..... G. .....1.....2..... H. .....1.....2..... I. .....1.....2.....	
10	Pada bulan lalu, apakah Ibu menerima berita atau pesan dari : *On the last month, did you receive news or message from :* BACAKAN PILIHAN JAWABAN ; JAWABAN BOLEH LEBIH DARI SATU		
	A. Radio B. Koran *Newspaper* C. Televisi *Television*	YA *YES* TIDAK *NO* A. .....1.....2..... B. .....1.....2..... C. .....1.....2.....	
11	Apakah status kepemilikan rumah yang saat ini ibu tempati? JAWABAN HANYA SATU; JANGAN BACAKAN PLIHAN JAWABAN *What is the ownership status of your house?*	Milik sendiri *Own* .....1 Milik orangtua/kel *Parents Belong*.....2 Angsuran *Installmen*.....3 Kontrak/sewa *Rent*.....4 Dinas *Goverment Belongs..5* Lain-lain *Other*, sebutkan *Mention*_____6	
12.A	Apakah saat ini ibu bekerja untuk mendapatkan uang? *Do you work for get some money?* JAWABAN HANYA SATU	Ya *Yes*.....1 Tidak *No*.....2	☐12.G
12.B	Dimana ibu bekerja? *Where do you work?*	Di rumah *Inside home*.....1 Di luar rumah *Outside home*.....2	☐12.F
12.C	Berapa hari dalam 1 minggu ibu bekerja di luar rumah? *How many day do you work on the offside home?*	_____ hari *Day* Tidak rutin *Non Routine* 97	
12.D	Pada hari dimana ibu bekerja, berapa jam dalam 1 hari ibu meninggalkan rumah (termasuk waktu dalam perjalanan) *On the day when you work, how many hour you leave your home?*	_____ jam *hour*	
12.E	Pada waktu ibu bekerja diluar rumah, siapa yang biasanya menjaga dan mengasuh anak Ibu? *When you work on the offside of home, who ussualy care your child?*	Pengasuh/pembantu *Care giver*.....1 Anak *Child*.....2 Orang tua/mertua *Parent/Parent in law*....3 Tetangga *Neighboor*.....4 Keluarga *Family*.....5 Day Care.....6 Lainnya *Other*, Sebutkan *Mention*_____7	
12.F	Mulai anak berumur berapa bulan Ibu mulai bekerja setelah melahirkan? (ANAK UMUR TERAKHIR) *Since what your child's age you start to work on the offside of your home?*	|___|___| bulan *Month*	
12.G	Berapa jumlah anak **balita** yang Ibu asuh di rumah ini? How many baby under 5 years do you give care in this home?	Jumlah anak *Number of children* |___|___|	
C. CHILD SPACING			

13.A	Pada usia berapa ibu **pertama kali hamil**? What old did you get the first pregnant? TERMASUK YANG MENINGGAL DAN ABORTUS/KEGUGURAN	|___|___| tahun *Year*	
13.B	Apakah sebelum hamil/menikah, Ibu pernah mendapat informasi atau konseling tentang kesehatan? *Did you get counseling or information about health before you got married?*	Ya *Yes* .....1 Tidak *No* 2	☐**13.D**
13.C	Apa topik informasi/konseling tersebut? *What is the topic on that counseling or information?* TANYAKAN "ADA LAGI" JANGAN BACAKAN PILIHAN JAWABAN, JAWABAN BOLEH LEBIH DARI		
	A. Kesehatan Ibu (ibu hamil; bersalin; menyusui) *Mother Care*..... B. Kesehatan dan perawatan anak *Child Care*..... C. Gizi ibu dan anak Mother and Child Nutrition..... D. KB *Contraception*..... E. Lainnya *Other*, sebutkan *Mention* _____	YA TIDAK A. .....1.....0 B. .....1.....0 C. .....1.....0 D. .....1.....0 E. .....1.....0	
13.D	Berapa jumlah anak yang pernah ibu lahirkan? *How many children did you give birth to?* TERMASUK ANAK YANG MENINGGAL DUNIA DAN LAHIR MATI. TIDAK TERMASUK ABORTUS/KEGUGURAN (< 20 minggu)	Jumlah yang dilahirkan *Number of Birth* |___|___|	
14.A	Siapa nama anak ibu yang terakhir, apa jenis kelaminnya, dan kapan lahirnya? *What is the name and sex of last child you gave birth to and when was she/he born?*	Anak termuda *Yougest Child* Nama *Name* _____ Jenis Kelamin *Sex* Laki-laki boy.....1 Perempuan girl.....2 Tanggal Lahir *Date of Birth* Tanggal *Day* |___|___| Bulan *Month* |___|___| Tahun *Year* |___|___|___|___|	**BILA ANAK HANYA SATU** ☐**15**
14.B	Siapa nama kakak langsung (NAMA), apa jenis kelaminnya, dan kapan lahirnya? *What is the name and sex of the child born just before the last one and when was he/she born?*	Kakak Anak Termuda *Yougest Brother* Nama *Name* _____ Jenis Kelamin *Sex* Laki-laki *Boy*.....1 Perempuan *Girl*.....2 Tanggal Lahir *Date of Birth* Tanggal *Day* |___|___| Bulan *Month* |___|___| Tahun *Year* |___|___|___|___|	
15	Menurut ibu, apakah KB alami itu? *What is the Lactation Amenorrhea Method?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?"		

	A. Cara mencegah kehamilan *How to prevent pregnancies* .... B. ASI eksklusif untuk cegah kehamilan *Exclusive breastfeeding to prevent pregnancy* ..... C. Menyusui untuk cegah kehamilan *Breastfeeding to prevent pregnancy* ..... D. Lain-lain *Other*, sebutkan *Mention*_____ E. Tidak tahu *Dont Know*.....	YA *YES* TDK *NO* A..... 1 ..... 0 B..... 1 ..... 0 C..... 1 ..... 0 ..... D..... 1 ..... 0 E..... 1 0	☐17
16	Menurut ibu, kondisi bagaimana yang harus dipenuhi untuk melakukan KB alami? *What are the conditions that need to be met for LAM to be used as a method of family planning?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?"		
	A. Bayi belum berumur 6 bulan *Babies 6 months old yet* ..... B. Ibu tidak haid *mother is not menstruating*..... C. Bayi menyusu lebih dari 8 kali dalam 1 hari *Babies breastfeed more than 8 times in 1 day*..... D. Bayi menyusu minimal 1 kali pada malam hari *Infants breastfed at least 1 time at night*..... E. Bayi menyusu siang dan malam *Infant feeding day and night*..... F. Bayi menyusu kapan saja ia mau *Babies breasfed whenever he wanted* G. Lain-lain *Other*, sebutkan *Mention*_____ H. Tidak tahu *Dont Know*	YA *YES* TDK *NO* A..... 1 ..... 0 B..... 1 ..... 0 C..... 1 ..... 0 D..... 1 ..... 0 E..... 1 ..... 0 F..... 1 ..... 0 G..... 1 ..... 0 H..... 1 0	
17	Apakah saat ini ibu atau suami Ibu sedang menggunakan suatu cara atau alat untuk menunda atau mencegah kehamilan? *Are you currently doing something or using any method to delay or avoid getting pregnant?*	Ya *Yes*.....1 Tidak *No* .....2 Tidak tahu *don't know* 9	☐19 ☐20
18	Metode KB apa yang ibu atau suami Ibu gunakan sekarang? *Are you currently doing something or using any method to delay or avoid getting pregnant?* JANGAN DIBACAKAN JAWABANNYA. TANDAI HANYA SATU JAWABAN JIKA RESPONDEN MENYEBUTKAN LEBIH DARI 1 METODE, TANYAKAN 'Metode utama apa yang Ibu atau suami Ibu gunakan untuk mencegah kehamilan?'	**KB Tradisional** KB alami *Natural Contraception*.....1 Jamu *Herb*.....2 Kalender *Calender*.....3 Senggama terputus *Coitus Interuptus*..... .....4 **KB modern** Pil *Pill* ....5 Suntikan *Injection*..... ..6 Susuk/implant *Implant*.... ..7 IUD/Spiral ....8 Kondom *Condom*..... ..9 MOP (Steril pada pria) .....10 MOW (Steril pada anita)....11 Lain-lain *Other*, ...96 Sebutkan *Mention*_____	☐20
19	Mengapa ibu tidak menggunakan alat KB (modern)? Why don't you use family planning? JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?"		

	A. Dilarang agama *Religiously forbidden*.....	YA TDK A..... 1 0	
	B. Sedang menyusui *Nursing*	B..... 1 0	
	C. Ibu hamil lagi *Mother was pregnant again*	C..... 1 0	
	D. Nasehat suami *Advice husband*	D..... 1 0	
	E. Nasehat orang tua *Advice parents*	E..... 1 0	
	F. Nasehat anggota keluarga lain *Advice of other family members*	F..... 1 0	
	G. Suami yang menggunakan alat KB *The husband who used contraceptive*	G..... 1 0	
	H. Lain-lain *Other*, sebutkan *Mention*_____	H..... 1 0	
20	Apakah dalam satu bulan terakhir ada yang pernah memberikan penyuluhan tentang KB alami kepada ibu? *In the past month has anyone talked to* you about LAM*?*	Ya *Yes*.....1 Tidak *No*.....2 Tidak tahu *don't know*.....9	☐**22A** ☐**22A**
21	Siapa yang memberikan penyuluhan tentang KB alami tersebut? *Who counseled you on LAM?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?"		
	A. Dokter *Doctor*.....	YA *YES* TDK *NO* A..... 1 0	
	B. Perawat *Nurse*.....	B..... 1 0	
	C. Bidan Puskesmas *Midwife in Center of Community Health*	C..... 1 0	
	D. Bidan swasta *Private Midwife*.....	D..... 1 0	
	E. Bidan desa *Midwife in Village*.....	E..... 1 0	
	F. Nakes lain *Other health worker*.....	F..... 1 0	
	G. Kader *Cadre*.....	G..... 1 0	
	H. Keluarga/Teman *Family/Friend*.....	H..... 1 0	
	I. Tidak ada *Nothing*.....	I..... 1 0	
	J. Lain-lain *Other*, sebutkan *Mention*_____	J 1 0	

Pertanyaan berikut ini ditujukan untuk anak terkecil yang berumur < 24 bln
The following questions are intended for the youngest child aged <24 months..

D. MATERNAL AND NEWBORN CARE

22.A	Ketika Ibu hamil (NAMA) apakah Ibu melakukan pemeriksaan kehamilan? Jika Ya, Kepada siapa ibu memeriksakan kehamilan tersebut? *When you were pregnant, did you get a shot in your arm to prevent tetanus or convulsions Rapid Catch Question 1* JANGAN BACAKAN JAWABAN; JAWABAN BOLEH LEBIH DARI SATU TANYAKAN SIAPA LAGI?		
	A. Dokter *Doctor*.....	YA TDK A..... 1 0	
	B. Perawat *Nurse*.....	B..... 1 0	
	C. Bidan Puskesmas *Midwife in Center of Health Community*.....	C..... 1 0	
	D. Bidan swasta *Private Midwife*.....	D..... 1 0	
	E. Bidan desa *Midwife in Village*.....	E..... 1 0	
	F. Nakes lain *Other health worker*.....	F..... 1 0	
	G. Kader *Cadre*	G..... 1 0	
	H. Keluarga/Teman *Family/Friend*.....	H..... 1 0	
	I. Tidak pernah periksa *Never*.....	I 1 0	☐**25**
	J. Lain-lain, sebutkan_*Other, Mention*_____	J 1 0	

22.B	Selama Ibu hamil (NAMA) berapa kali ibu memeriksakan kehamilan? *During pregnancy, how many time did you come to check your pregnancy?*	_____ kali *time* Tidak ingat *don't remember*.....98	
22.C	Selama hamil (NAMA), berapa kali ibu menerima suntikan? *While pregnant with (name), how many times did you receive such an injection?* *Rapid Catch question 2*	Satu kali *Once* ....1 Dua kali *Twice* .....2 Tiga kali atau lebih *Three timeds or more* .....3 Tidak ingat *Dont remember*.....9	
22.D	Sebelum ibu hamil, apakah ibu menerima suntikan anti tetanus, termasuk pada kehamilan ibu sebelumnya atau di antara kehamilan? *Did you receive any tetanus toxoid injection at any time before that pregnancy, including during a previous pregnancy or between pregnancies?*	Ya *Yes*.....1 Tidak *No* .....2 Tidak ingat *don't remember* 9	
23	Selama memeriksakan kehamilan, apakah ibu pernah diberikan informasi tentang persalinan, Gizi Ibu dan bayi, ASI/menyusui? *During you checked the pregnancy, were you got information about pregnancy, maternal and child nutrition, Breastmilk/lactation?*	Ya *Yes* .....1 Tidak *No* 2	☐**25**
24	Informasi apa yang diberikan? PILIHAN JAWABAN TIDAK DIBACAKAN *What is the information were you got?*		

	YA *YES* TIDAK *NO*
A. Makan ekstra 1 kali/hari selama hamil *eat extra meal 1/day*	A. .....1.....0
B. Konsumsi Tablet zat besi selama hamil *consume Fe tablet during pregnancy*.....	B. .....1.....0
C. Minum obat anti cacing 1 x saat hamil *Once Anti-worm medication during pregnancy*.....	C. .....1.....0
D. ASI Eksklusif (ASI saja 0-6 bulan) *Exclusive Breastfeeding*.....	D. .....1.....0
E. Colostrum	E. .....1.....0
F. IMD *Initiation of Breastfeeding*.....	F. .....1.....0
G. Menyusui sesuka bayi *Breastfed whenever baby wants to*.....	G. .....1.....0
H. Cara Menyusui How to breastfed..... (posisi menyusui; menyusui dari 1 payudara sampai kosong)	H. .....1.....0
I. Makan ekstra 2x/hari untuk menjaga kesehatan ibu dan bayi *Eat extra 2 time/day to maintain the health of mother and child*.....	I. .....1.....0
J. Mengkonsumsi Vitamin A untuk Ibu *Consume Vitamin A for Mother*.....	J. .....1.....0
K. Mulai memberi makanan lunak pada bayi setelah berusia 6 bulan *Start giving soft foods for infants after the age of 6 months*	K. .....1.....0
L. Memberi makanan lunak yang mengandung telur, kacang-kacangan *Give soft foods that contain eggs, nuts*	L. .....1.....0
M. Memberi bayi sayuran dan bauh yang bervariasi (sayuran hijau, alpukat, mangga, pisang) *Give baby vegetables and a varied bauh (green vegetables, avocado, mango,banana)*	M. .....1.....0
N. Saat anak berusia 12 bulan, Pisahkan tempat makan anak dan temani anak makan untuk memastikan anak makan makanan yang telah dipersiapkan *At the age of 12 months, Separate dining accompany the child and the child to eat tomake sure children eat food that has been prepared*	N. .....1.....0
O. Mencuci tangan dengan sabun sebelum menyiapkan makanan dan menyuapi anak makan *Washing hands with soap before preparing food and feeding children eat*	O. .....1.....0
P. Berikan kapsul Vitamin A setiap 6 bulan mulai bayi berusia 6 bulan	P. .....1.....0

	Give Vitamin A capsules every 6 months starting 6 months old baby ……. Q. Berikan obat anti cacing sejak anak berusia 1 tahun *Give the anti-worm drug from children aged 1 year*…….. R. Gunakan garam beryodium untuk memasak makanan *Use iodized salt to cook food* …….. S. Gunakan alat KB untuk menunda kehamilan *Use birth control to postpone pregnancy* …….. T. Lainnya, Sebutkan *other, mention*_____	Q. ……1……..0 R. ……1……..0 S. ……1……..0 T. ……1……..0	
25	Di mana ibu melahirkan (NAMA)? Where was the baby born?	Rumah *Home*……1 Klinik *Clinic*…… ……2 Rumah bidan/BPS *Midwife Private Practice*……3 Puskesmas *Center of Community of Health Service*……4 Rumah sakit *Hospital* …. ……5 Lain-lain…… ……6 Sebutkan *Other, Mention*_____	
26	Dimana lokasi ibu melahirkan? *In what location did you give birth?*	Jakarta …… ……1 Luar Jakarta *Outside of Jakarta*……2 Sebutkan *Mention*_____ Tidak ingat *Dont remember*……3	☐**28.A**
27	Bila di luar kota Jakarta, apakah itu di perkotaan atau pedesaan? *If it in the outside of Jakarta, is that urban or rural area?*	Perkotaan *Urban*…… ……1 Pedesaan *Rural*…… ……2 Tidak tahu *don't know*…. ……3	

28.A	Siapa yang **menolong** ibu saat melahirkan (NAMA)? Siapa lagi? Who assist your delivey? Who else? JAWABAN BOLEH LEBIH DARI SATU *ANSWER CAN MORE THAN ONE* PROBE JENIS PROFESINYA DAN CATAT YANG DISEBUTKAN. JIKA IBU MENJAWAB TIDAK ADA YANG MENOLONG, TANYAKAN SIAPA YANG MENEMANI PADA SAAT PERSALINAN.		
	A. Dokter *Doctor* …… B. Perawat *Nurse*…… C. Bidan Puskesmas *Midwife in Center of Health Community* …… D. Bidan swasta *Private Midwife*…… E. Bidan desa *Midwife in Village*…… F. Nakes lain *Other health worker*…… G. Kader *Cadre* …… H. Keluarga/Teman *Family/Friend* …… I. Tidak pernah periksa *Never* …… J. Lain-lain, sebutkan_*Other, Mention*_____	YA TIDAK A ……1 ….. 0 B ……1 ….. 0 C ……1 ….. 0 D ……1 ….. 0 E……1 ….. 0 F……1 ….. 0 G ……1 ….. 0 H ……1 ….. 0 I ……1…… 0 J ……1…… 0	
28.B	Segera setelah bayi lahir dan sebelum plasenta/ari ari lahir apakah tenaga kesehatan: *Immediate alter the baby born and before the cord born did the health waorker:* BACAKAN JAWABAN DAN ISI PILIHAN JAWABAN YANG SESUAI *READ THE OPTIONS AND FILL THE ANSWER*		

	A. Memberi suntikan di paha yang gunanya untuk mencegah perdarahan *Giving an injection in the thigh that point to prevent bleeding* B. Memegang perut dan menegangkan tali pusat untuk membantu keluarnya plasenta/ari ari *Hold your stomach and tense the umbilical cord to help the placenta*	Ya TIDAK TIDAK TAHU *YES NO DONT KNOW* A. .....1.....0.....9 B. .....1.....0.....9	
28.C	Segera setelah plasenta lahir apakah ada orang yang memijit perut bagian bawah untuk membuat kontraksi dan mencegah perdarahan yang banyak *Immediate after the cord born was there someone massage you stomach to make contraction or prevet bleeding?*	Ya TIDAK TIDAK TAHU *YES NO DONT KNOW* ..1.....0.....9	
Pertanyaan 29-31 mengacu pada ibu setelah persalinan anak yang terakhir			
29	Apakah ada **tenaga kesehatan** yang memeriksa **kesehatan ibu** setelah melahirkan (NAMA) baik di fasilitas kesehatan maupun di rumah? *Was there a health worker or traditional healer who checked your health after you gave birth?*	Ya *Yes* ..... 1 Tidak *No* 2	☐**32**
30	Berapa jam atau hari atau minggu setelah lahir, setelah melahirkan (NAMA) **ibu** diperiksa pertama kali ? *How long after you gave birth did you get your first checkup?* JIKA KURANG DARI SATU HARI LINGKARI 0 DAN CATAT BERAPA JAM; JIKA LEBIH DARI 1 HARI NAMUN KURANG DARI SATU MINGGU LINGKARI 1 DAN CATAT BERAPA HARI; JIKA LEBIH DARI 7 HARI LINGKARI 2 DAN CATAT BERAPA MINGGU	Jam *Hour* 0 ☐☐ Hari *Day* 1 ☐☐ Minggu *Week* 2 ☐☐ Tidak ingat.....998	
31	Siapa yang memeriksa ibu waktu itu? *Who did the check up?* UNTUK MENDAPATKAN INFORMASI TENAGA KESEHATAN YANG PALING KOMPETEN YANG PERNAH MEMERIKSA IBU, GALI DENGAN PERTANYAAN 'ADA YANG LAIN?' DAN CATAT SEMUA YANG RESPONDEN SEBUTKAN		
	A. Dokter *Doctor*..... B. Perawat *Nurse*..... C. Bidan Puskesmas *Midwife in Center of Community of Health Service* D. Bidan swasta *Private Midwife* ..... E. Bidan desa *Midwife in Village* ..... F. Bidan Rumah Sakit *Midwife in Hospital*..... G. Kader *Cadre* ..... H. Keluarga/Teman *Family / Friend* ..... I. Tidak ada *No one*..... J. Lain-lain, sebutkan *Other, Mention*_____	YA *YES* TIDAK NO A .....1 ..... 0 B .....1 ..... 0 C .....1 ..... 0 D .....1 ..... 0 E.....1 ..... 0 F.....1 ..... 0 G .....1 ..... 0 H .....1 ..... 0 I .....1..... 0 J .....1..... 0	
Pertanyaan 32-34 mengacu pada anak terakhir setelah kelahirannya **Questions 32-34 refer to the last child after birth**			
32	Setelah (NAMA) lahir, apakah (NAMA) diperiksa oleh **tenaga kesehatan**? *After (name) was born, did the health provider check the health of (name)?* *Rapid Catch question 4*	Ya *Yes* ..... 1 Tidak *No* 2	☐**35**

33	Berapa jam atau hari atau minggu setelah (NAMA) lahir diperiksa pertama kali ? *How long after (name) was born was he/she checked?* *Rapid Catch question 4* JIKA KURANG DARI SATU HARI LINGKARI 0 DAN CATAT BERAPA JAM; JIKA LEBIH DARI 1 HARI NAMUN KURANG DARI SATU MINGGU LINGKARI 1 DAN CATAT BERAPA HARI; JIKA LEBIH DARI 7 HARI LINGKARI 2 DAN CATAT BERAPA MINGGU	Jam *Hour* 0 ☐☐ Hari *Day* 1 ☐☐ Minggu *Week* 2 ☐☐ Tidak ingat *Dont remember*..... 998	☐35
34.A	Siapa yang memeriksa (NAMA) waktu itu? *Who checked (name) at that time?* UNTUK MENDAPATKAN INFORMASI TENAGA KESEHATAN YANG PALING KOMPETEN YANG PERNAH MEMERIKSA IBU, GALI DENGAN PERTANYAAN 'ADA YANG LAIN?' DAN CATAT SEMUA YANG RESPONDEN SEBUTKAN		
	A. Dokter *Doctor* ..... B. Perawat *Nurse*..... C. Bidan Puskesmas *Midwife in Center of Health Community* ..... D. Bidan swasta *Private Midwife*..... E. Bidan desa *Midwife in Village*..... F. Nakes lain *Other health worker*..... G. Kader *Cadre* ..... H. Keluarga/Teman *Family/Friend* ..... I. Tidak pernah periksa *Never*..... J. Lain-lain, sebutkan_*Other, Mention*_____	YA TIDAK A .....1 ..... 0 B .....1 ..... 0 C .....1 ..... 0 D .....1 ..... 0 E.....1 ..... 0 F.....1 ..... 0 G .....1 ..... 0 H .....1 ..... 0 I .....1..... 0 J .....1..... 0	
34 B	Setelah pemeriksaan pertama, kapan (NAMA) diperiksa lagi oleh tenaga kesehatan? *After the first check, when (NAME) is checked again by health?* PILIH JAWABAN YANG SESUAI. JAWABAN BOLEH LEBIH DARI SATU. PILIHAN JAWABAN JANGAN DIBACAKAN *SELECT THE APPROPRIATE ANSWER. NOT MORE THAN ONE ANSWER.ANSWER OPTIONS DO NOT read*		
	A. 3-7 Hari *Day*..... B. 8-28 hari *Day*..... C. Lainnya, Sebutkan *Other, Mention*_____	YA *YES* TIDAK *NO* A. .....1.....0 B. .....1.....0 C. .....1.....0	
35	Kadang-kadang bayi yang baru lahir terutama yang berusia kurang dari 1 bulan, mengalami sakit yang parah dan harus segera dibawa ke fasilitas kesehatan. *Sometimes newborns especially those younger than 1 month, experiencing severe pain and should be immediately brought to health facilities.* Menurut Ibu, gejala-gejala apa yang membuat ibu **harus** membawa bayi ke fasilitas kesehatan segera? *According to Mother, the symptoms of what makes a mother must carry the baby to a health facility immediately?* "APAKAH ADA LAGI??" JAWABAN BOLEH LEBIH DARI SATU; JANGAN BACAKAN PILIHAN JAWABAN *"IS THERE AGAIN??" NOT MORE THAN ONE ANSWER, DO NOT READ ANSWER CHOICES* JAWABAN BOLEH LEBIH DARI 1 *ANSWER CAN MORE THAN 1*		

		YA TIDAK	
	A. Kejang *Seizures*.....	A..... 1 0	
	B. Demam *Fever* ,,.....	B..... 1 0	
	C. Tidak bisa menyusu atau makan *Unable to breastfeed or eat*	C..... 1 0	
	D. Nafas cepat atau sesak *Sooner or shortness of breath*	D 1 0	
	E. Badan bayi teraba *Agency palpable baby*	E..... 1 0	
	F. Bayi terlalu kecil atau *BBLR Babies born too small* or Low Baby Birth.....	F..... 1 0	
	G. Bayi tampak kuning *The baby looks yellow*	G..... 1 0	
	H. Perut bayi tambah membengkak *Plus the baby's stomach to swell*	H 1 0	
	I. Bayi tidak sadar *Babies do not realize*	I 1 0	
	J. Adanya nanah atau kemerahan di pangkal tali pusat, mata atau kulit *The presence of pus or redness at the base of the umbilical cord, eyes or skin*	J 1 0	
	K. Lainnya, Sebutkan *Other, Mention*_____	K.....1..... 0	

D. MENYUSUI DAN PEMBERIAN MAKANAN PADA BAYI DAN ANAK (PMBA)
E. BREASTFEEDING AND FOOD PROVISION IN INFANT AND CHILD

36.A	Apakah ibu pernah menyusui/memberikan Air Susu Ibu (ASI) untuk (NAMA)? *Have you ever breastfed (name)?* *IYCF question 1*	Ya *Yes* .....1 Tidak *No* 2	☐**37.A**
36.B	Mengapa ibu tidak pernah menyusui (NAMA)*?* *Why didn't you breastfed (name)?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?"		
		YA TDK	
	A. Bayi sakit *baby sick*.....	A 1 0	
	B. Ibu sakit *mother sick*.....	B 1 0	
	C. Ada masalah payudara *breast problem*	C 1 0	
	D. Tidak ada ASI *No breast milk*.....	D.....1 0	☐**39**
	E. Ibu bekerja *working mother*.....	E 1 0	
	F. Bayi tidak mau *baby didn't want*.....	F 1 0	
	G. Agar payudara tidak berubah bentuk *so breast wouldn't change shape*	G.....1 0	
	H. Nasehat suami *husband's advice*.....	H.....1 0	
	I. Nasehat tenaga kesehatan *advice from health professional*	I 1 0	
	J. Lain-lain, sebutkan *Other, Mention*.....	J.....1 0	

Sekarang saya akan menanyakan tentang pengalaman Ibu saat melahirkan (NAMA)
Now I will ask about the experience of mother at delivery (NAME)

37.A	Apakah ibu melahirkan dengan cara normal atau operasi/SC? *Did you birth with normal methode or operation surgery?*	Normal.....1 Operasi/SC *Operation Sectio Caesaria*.....2 Tidak Tahu *Don't know*.....9	
37.B	Berapa umur kehamilan Ibu saat melahirkan (NAMA)? *How old when did you birth (Name)*	Cukup bulan/9 bulan *aterm*.....1 Kurang Bulan / < 9 bln *Preterm*...2 Lebih bulan 3	

37.C	Apa yang dilakukan penolong persalinan pada (NAMA) segera setelah lahir? *What the assistant delivery did to (Name) immediate after delivery?* KALAU LAHIR DENGAN CARA OPERASI/S.C..: "Apa yang dilakukan pada (NAMA) segera setelah ibu sadar?" KALAU IBU TDK PAHAM PERTANYAAN: "Begitu (NAMA) lahir apa yg dilakukan penolong persalinan pada (NAMA)?" PASTIKAN BAHWA JAWABAN IBU ADALAH HAL PERTAMA YG DILAKUKAN OLEH PERSALINAN SETELAH BAYI LAHIR JANGAN BACAKAN PILIHAN JAWABAN. TUNGGU JAWABAN SPONTAN IBU	Langsung diletakkan di dada/perut ibu tanpa dimandikan lebih dahulu, kulit ibu bersentuhan dengan kulit bayi *Directly placed on the chest / abdomen mother without being bathed in advance, mother skin touch with baby's skin..... .. 1* Dimandikan *Bathed* .....2 Bukan salah satu di atas.....3 Sebutkan apa tindakannya *None of the above, Please list any actions Mention*_____ _____ Tidak ingat /tidak tahu .....9 *Do not remember / do not know*	☐37.E
37.D	Berapa lama setelah lahir (NAMA) mulai diletakkan di dada/perut ibu? *How many time after birth (Name) start to be put on your breast/stomach?* JIKA KURANG DARI 1 JAM, CATAT BERAPA MENIT, JIKA KURANG DARI 24 JAM, CATAT BERAPA JAM. SELAIN ITU, CATAT JUMLAH HARI.	Menit *Minute* _____ Jam *Hour* _____ Hari *Day* _____ Tidak ingat *Don't remember*.....998	
37.E	Berapa lama (NAMA) dibiarkan di dada / perut ibu? *How many time (Name) let be put on your breast/stomach ?* JIKA KURANG DARI 1 JAM, CATAT BERAPA MENIT, JIKA KURANG DARI 24 JAM, CATAT BERAPA JAM.	Menit *Minute* _____ Jam *Hour* _____ Tidak ingat *Don't remember*..... 998	
37.F	Apakah (NAMA) dibiarkan di dada ibu sampai menyusu waktu itu? *On that time did (Name) let be put on your breast until breastfed?*	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat don't remember.....9	☐38 ☐38
37.G	Apakah (NAMA) dibiarkan menyusu sampai melepaskan sendiri puting ibu atau tertidur? *Did (name) allowed to breastfed until releasing his own mother's nipples or asleep?*	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat *don't remember*..... 9	
38	Selama 3 hari pertama setelah melahirkan, apakah ibu memberikan (NAMA) cairan putih kekuning-kuningan (**kolostrum**/susu jolong) yang keluar dari payudara ibu? *In the 3 days after birth, did you give (name) the yellowish (colostrums) that came out of your breast?* *IYCF q.* 3	Ya *Yes*..... Tidak *No* ..... 2 Tidak ingat *don't remember.9*	
39	Selama tiga hari pertama setelah lahir, apakah (NAMA) diberikan makanan/minuman lain selain ASI? *In the first 3 days after birth, did (name) get any food/drink besides breast milk? IYCF q 4*	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat don't remember.....9	☐44 ☐44

40	Makanan/minuman apa yang diberikan kepada (NAMA)? Ada yang lain, bu ? *What food/drink did you give to (name)? anything else?* JANGAN BACAKAN JAWABAN		
		YA TDK	
	A. Susu (selain ASI) *milk* ..... B. Air putih *water*..... C. Gula/air gula *sugar water* ..... D. Air tajin *Gripe water*..... E. Larutan gula garam *ORS* ..... F. Jus buah *fruit juice* ..... G. Susu formula *Breast milk subtitute* ..... H. Teh/infusions *Tea* ..... I. Madu *honey* ..... J. Lain-lain. Sebutkan *Other, Mention*.....	A.....1 ..... 0 B.....1 ..... 0 C.....1 ..... 0 D.....1 ..... 0 E.....1 ..... 0 F.....1 ..... 0 G.....1 ..... 0 H.....1 ..... 0 I.....1 .....0 J 1 0	
41	Berapa lama setelah lahir, (NAMA) mulai diberikan makanan atau minuman lain selain ASI tersebut? *How long after birth, (NAME) began to be given food or drink other than breast milk is?* JIKA KURANG DARI SATU HARI LINGKARI 0 DAN CATAT BERAPA JAM; JIKA KURANG DARI SATU MINGGU LINGKARI 1 DAN CATAT BERAPA HARI; JIKA LEBIH DARI 7 HARI LINGKARI 2 DAN CATAT BERAPA MINGGU; JIKA LEBIH DARI 4 MINGGU LINGKARI 3 DAN CATAT BERAPA BULAN	Jam *Hour* 0 |___|___| Hari *Day* 1 |___|___| Minggu *Week* 2 |___|___| Bulan *Month* 3 |___|___| Tidak ingat dont remember .....998 Tidak tahu *Dont know*..999	
42	Siapa saja yang menganjurkan ibu memberikan makanan/minuman lain selain ASI tersebut? *Who advised you to give food/drink other than breast milk?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "SIAPA LAGI, BU?"		
		YA TDK	
	A. Suami *husband*..... B. Orang tua/mertua *parents*..... C. Anggota keluarga lainnya *other family member*..... D. Tetangga *neighbor*..... E. Dukun bayi *TBA*..... F. Perawat *nurse* ..... G. Bidan desa *village midwife*..... H. Bidan swasta *auxilliary midwife* ..... I. Bidan puskesmas *Midwife in Center of community Health Service* J. Dokter *Doctor* ..... K. Diri sendiri myself ..... L. Lain-lain, sebutkan *Other, Mention*.....	A.....1 ..... 0 B.....1 ..... 0 C.....1 ..... 0 D.....1 ..... 0 E.....1 ..... 0 F.....1 ..... 0 G.....1 ..... 0 H.....1 ..... 0 I.....1 .....0 J.....1 .....0 K.....1 .....0 L 1 0	

43	Apa alasan diberikan makanan/minuman selain ASI tersebut? *Why did you give food/drink other than breast milk?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?"		
		YA TDK	
	A. Bayi sakit *sick child* ..... B. Ibu sakit *sick mother*..... C. Ada masalah payudara *breast problem*	A.....1 ..... 0 B.....1 ..... 0 C.....1 0	

	D. ASI tidak/belum keluar *Nobreast milk* ..... E. Ibu bekerja *working mother*..... F. Bayi tidak mau *baby didn't want*..... G. Agar payudara tidak berubah bentuk breasts isn't *change* ..... H. Saatnya menyapih *weaning* ..... I. Bayi menangis terus *baby kept criying*..... J. ASI tidak mencukupi *breastmilk not enough*..... K. Ibu hamil lagi *pregnant* ..... L. Menggunakan alat KB *using contraception* ..... M. Nasehat suami *husband's advice* ..... N. Nasehat dokter atau perawat *doctor or nurse advice*..... O. Nasehat orang tua *parents advice* ..... P. Nasehat anggota keluarga lain *other family member's advice* Q. Nasehat tetangga/teman *neighbor's or friend's advice*..... R. Lain-lain, sebutkan *Other, Mention*_____	D..... 1 ..... 0 E..... 1 ..... 0 F..... 1 ..... 0 G..... 1 ..... 0 H..... 1 ..... 0 I..... 1 .....0 J ..... 1 .....0 K..... 1 .....0 L ..... 1 .....0 M ..... 1 .....0 N..... 1 .....0 O ..... 1 .....0 P..... 1 .....0 Q ..... 1 .....0 R..... 1 0	
44	Apakah ibu MASIH menyusui / memberikan ASI pada (ANAK)? *Are you still breastfeeding?* *IYCF q 6*	Ya *Yes* ..... 1 Tidak *No* 2	☐**46**
45	Sampai (NAMA) berusia berapa bulan ibu menyusuinya / memberinya ASI? *How long did you breastfeed (name)?* JIKA KURANG DARI SATU BULAN, TULIS "00" BLN.	Bulan *Month*..... |___|___|	
46	Apakah semalam atau kemarin (NAMA) minum dari botol/dot? *Did (name) get any drink from a bottle yesterday during the day or night?* *IYCF q 8*	Ya *Yes*..... 1 Tidak *No*..... 2 Tidak ingat *don't remember* 9	

47	Sekarang saya akan bertanya tentang minuman atau makanan yang ibu berikan pada (NAMA) sejak kemarin pagi sampai malam? *Now I want to ask you about drink you gave (name) yesterday* **Apakah (NAMA) minum:** BACAKAN DAFTAR MINUMAN DAN MAKANAN DIBAWAH INI MULAI DARI ASI		
	A. ASI *Breastmilk*..... B. Air Putih *Water*..... C. Susu Formula Bayi *Formula milk*..... D. Makanan bayi/anak yang dijual dalam kemasan (cerelac, sun dll) *Food infants / children that are sold in packs* ..... E. Bubur lain *Other porridge* (bukan bubur kemasan) *No pulp packaging)*.....	YA TDK A .....1 ..... 0 B .....1 ..... 0 C .....1 ..... 0 D.....1 ..... 0 E 1 0	
48	Sekarang saya akan bertanya tentang makanan atau minuman yang diberikan kepada (NAMA) sepanjang hari kemarin sejak pagi hingga malam. *Now I want to ask you about food you gave (name) yesterday.* Saya ingin mengetahui apakah (NAMA) mendapatkan makanan atau minuman yang akan saya sebutkan berikut ini, termasuk bila itu dikombinasikan dengan makanan lain **Apakah (NAMA) makan/minum**: *Did (Name) eat/drink:*		

		YA TIDAK	
	GROUP 1: Produk berbahan dasar susu *milk-based products*		
	A. Susu formula Bayi yang diproduksi dan dijual dalam kemasan *Infant formula milk produced and sold in packs*…… ……..	A. ...1.....0	
	B. Susu dalam kaleng, susu bubuk atau susu segar dari hewan *Canned milk, powdered milk or fresh milk from the animals* ……..	B. ...1.....0	
	C. Keju, yogurt, atau produk-produk berbahan dasar susu lainnya *Cheese, yogurt, or products made from other milk*…… ……..	C. ...1.....0	
	GROUP 2: Grain/Biji-bijian *Grain / Cereals*	D. ...1.....0	
	D. Makanan bayi dan anak yang dijual dalam kemasan *Baby food and children are sold in packs*……	E. ...1.....0	
	E. Bubur lainnya *Other Porridge* ……	F. ...1.....0	
	F. Roti, nasi, mie atau makanan lain yang berbahan dasar biji *Bread, rice, noodles or other food-based seed* ……	G. ...1.....0	
	G. Kentang, ubi, ketela atau makanan lain dari akar-akaran *Potatoes, yams, sweet potatoes or other foods from the roots*…… ……..		
	GROUP 3: Sayur Mayur Kaya Vitamin A *Vegetables Rich in Vitamin A*		
	H. Labu kuning, wortel, atau jenis kentang-kentangan yang warna dagingnya kuning atau oranye *Pumpkin, carrots, potatoes or other types of meat-kentangan the color yellow or orange* ……..	H. ...1.....0	
	I. Sayuran daun berwarna hijau tua *Dark green leafy vegetables* ……	I. ...1.....0	
	J. Mangga, papaya (jenis2 buah lokal yang kaya vitamin A) *Mango, papaya (jenis2 local fruits rich in vitamin A)*……	J. ...1.....0	
	K. Makanan yang dibuat dari minyak kelapa atau minyak kacang *Foods made from coconut oil or peanut oil* …… ……	K. ...1.....0	
	GROUP 4: Jenis buah atau sayur lainnya *type of fruit or other vegetable*		
	L. Buah atau sayuran lain seperti jeruk, nanas, anggur *Fruits or vegetables such as oranges, pineapple, grapes*……	L. ...1.....0	
	GROUP 5: Telur *Eggs*	M. ...1.....0	
	M. Segala macam telur *All sorts of eggs*……		

	GROUP 6: Daging, unggas, ikan *Meat, poultry, fish* N. Hati, ginjal, jantung atau jeroan lainnya *Liver, kidney, heart or other organ meats* …… O. Segala macam daging seperti daging sapi, domba, kambing, ayam atau bebek *All kinds of meat such as beef, lamb, goat, chicken or duck* …… P. Kerang-kerangan atau ikan segar maupun yang dikeringkan *Shellfish or fish, fresh or dried*…… …… Q. Keong, siput, serangga atau makanan protein hewani lainnya *Conch, snails, insects or other animal protein foods* …… **GROUP 7: Kacang-kacangan *Nuts*** R. Segala macam makanan yang dibuat dari kacang-kacangan *All kinds of foods made from nuts*…… …… **GROUP 8: Minyak atau Lemak *Oil or Fat*** S. Minyak, lemak, atau mentega atau makanan yang dibuat dari bahan-bahan minyak/lemak *Oil, grease, or butter or foods made from ingredients of oil / fat*……	N. ...1.....0 O. ...1.....0 P. ...1.....0 Q. ...1.....0 R. ...1.....0 S. ...1.....0	
	Cek jawaban: BERAPA BANYAK KELOMPOK MAKANAN (DARI KELOMPOK 1-8 DALAM TABEL DI ATAS) YANG ADA SETIDAKNYA SATU JAWABAN 'YA' ***HOW MUCH FOOD GROUP (GROUP OF 1-8 IN THE TABLEABOVE) THAT THERE IS AT LEAST ONE ANSWER 'YES'***	Jumlah *Total* : _____	
49	**Group 9 : Makanan Lain *Other Foods*** A. Teh atau kopi *Tea or coffee*…… B. Minuman lain *Other drink*…… C. Makanan yang mengandung gula seperti permen cokelat, permen, kue-kue atau biscuit *Foods that contain sugar such as chocolate candy, candy, cakes or biscuits* …… D. Makanan padat atau lunak lainnya *Solid food or other soft* ……	YA *YES* TIDAK *NO* A. ...1.....0 B. ...1.....0 C. ...1.....0 D. ...1.....0	
50	Berapa kali (NAMA) makan makanan padat, setengah-padat atau lunak (selain minuman) sepanjang hari kemarin sejak pagi hingga malam *How many times did (NAME) eat solid food, semi-solid or soft (except drinks) all day yesterday from morning until night* JIKA IBU MENJAWAB 7 ATAU LEBIH, TULIS "7" ADAPTASI PERTANYAAN INI DENGAN MENGGUNAKAN BAHASA LOKAL UNTUK MAKANAN LUNAK-PADAT YANG DIBERIKAN. Berbagai jenis makanan selingan yang kecil/snacks misalnya hanya beberapa gigitan saja juga **tdk dihitung** **CAIRAN JUGA TIDAK DIHITUNG**, TERMASUK MAKANAN SEPERTI SUP DENGAN SEDIKIT SAYURAN. GUNAKAN PROBING UNTUK MEMBANTU IBU MENGINGAT MAKANAN APA YANG DIMAKAN OLEH ANAK KEMARIN.	Berapa kali *How Many time*.....1 |___| Tidak tahu *dont know*.....88	

F. SUPLEMENTASI VITAMIN DAN IMUNISASI			
51.	Apakah setelah melahirkan (NAMA) **Ibu** pernah menerima kapsul Vitamin A	Ya *Yes*.....1	

A	(seperti ini)? *Did you ever get a Vitamn A capsule like this?* **TUNJUKKAN CONTOH BERWARNA MERAH**	Tidak *No*..... 2 Tidak ingat don't remember.....9	☐**51.C** ☐**51.C**
51. B	(Bila jawaban 'ya'), Dalam waktu 6 minggu setelah melahirkan (ANAK), berapa kali ibu menerima kapsul Vitamin A (seperti ini)? *Did you get a vitamin A capsule after 6 weeks you gave birth (name)*	Satu kali *Once*.....1 Dua kali *twice*.....2 Lebih dari 2 kali *more than two times*.....3	
DUA PERTANYAAN BERIKUT MENGENAI SI ANAK DAN HANYA DITANYAKAN PADA RESPONDEN DENGAN ANAK USIA 6 – 23 BULAN			
51. C	Apakah (NAMA) pernah menerima kapsul Vitamin A (seperti ini)? *Did (name) ever get a Vitamn A capsule like this?* TUNJUKKAN CONTOH KAPSULNYA BILA ANAK RESPONDEN BERUSIA **6-11 BULAN**, TUNJUKKAN CONTOH KAPSUL BERWARNA **BIRU** BILA ANAK RESPONDEN BERUSIA **12-23 BULAN**, TUNJUKKAN CONTOH KAPSUL BERWARNA **MERAH**	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat don't remember.....9	☐**52.A** ☐**52.A**
51. D	Apakah dalam 6 bulan terakhir (NAMA) menerima kapsul vitamin A ? *Did (name) get a vitamin A capsule in the past 6 months*	Ya *Yes*.....1 Tidak *No*.....2 Tidak ingat.*dont remember*.....9	
IMUNISASI ANAK			
52. A	Apakah ibu mempunyai Buku KIA *(BUKU PINK)* untuk Ibu? *Do you have a growth card or maternal health card?* JIKA YA, TANYAKAN, "Boleh saya lihat?"	Ya *Yes* .....1 Ya, tidak bisa menunjukkan *Yes, can't show* .....2 Tidak *No* .....3 Tidak tahu *dont know*.....9	
52. B	(Jika ibu tidak punya Buku KIA untuk si Anak) Apakah ibu punya KMS atau catatan lain tentang imunisasi dan Vitamin A yang diterima (ANAK)? JIKA YA: Boleh saya lihat? *(If the mother does not have MCH Books for the Children), Did the mother have a KMSor other record of immunization and Vitamin A that is received (CHILD)? IF YES: Can I see?*	Ya *Yes* .....1 Ya, tidak bisa menunjukkan *Yes, can't show* .....2 Tidak *No*.....3 Tidak tahu *dont know*.....9	☐**53.B** ☐**53.B** ☐**53.B**
53. A	SALIN TANGGAL IMUNISASI UNTUK DPT 1, DPT3, DAN CAMPAK DARI KARTU ATAU BUKU JIKA IMUNISASI TIDAK TERCATAT DI KMS ATAU BUKU KIA, ISI DENGAN 99/99/9999 *COPY DATE FOR IMMUNIZATION DPT 1 DPT 3, AND MEASLES OF CARDS OR BOOK.* *IMMUNIZATION RECORD IF NOT IN OR BOOK KIA KMS, WITH THE CONTENTS WITH 99/99/9999*	Tanggal *Day* Bulan *Month* Tahun *Year* DPT1... |___||___| / |___||___| / |___||___|___||___| DPT3.... |___||___| / |___||___| / |___||___|___||___| Campak... |___||___| / |___||___| / |___||___|___||___|	
53. B	Apakah (NAMA) pernah disuntik di daerah lengan yang gunanya untuk mencegah Campak/sakit tampek? *Did (name) ever get an immunization in the forearm to protect from measles?*	Ya *Yes* .....1 Tidak *No* .....2 Tidak tahu/ingat *dont know/dont remember* .....9 Tidak pernah diimunisasi *never*.....97	☐**55**
54	Oleh siapa (NAMA) paling sering di imunisasi? *By whom (name) most often in immunization?*		

	A. Dokter *Doctor*..... B. Perawat *Nurse*..... C. Bidan Puskesmas *Midwife in Center of Communitity Health service*..... D. Bidan swasta *Private MIdwife*..... E. Bidan desa *Midwife in Village*..... F. Bidan Rumah Sakit Midwife in hospital..... G. Lainnya, Sebutkan *Other, Mention*_____	YA *YES* TIDAK *NO* A..... 1 .....0 B..... 1 .....0 C..... 1 .....0 D ..... 1 .....0 E..... 1 .....0 F..... 1 .....0 G 1 0	
54.A	Dimana lokasi Fasilitas Kesehatan tersebut? (PERTANYAAN INI MENGACU PERTANYAAN NO.54) *Where is the location of its facility?*	Jakarta.....1 Luar Jakarta *Outside of Jakarta*.....2 Sebutkan *Mention*_____ Tidak ingat *don't remember*.....3	
54. B	Mengapa Ibu memilih fasilitas tersebut untuk imunisasi? Why do you choose its facility? **JANGAN BACAKAN PILIHAN JAWABAN**		
	A. Langganan Keluarga (sudah lama jg pelanggan) *Family sunscription* B. Sudah percaya; bisa/cepat sembuh; *It's believe, can/get better soon* C. Dekat dari rumah *is close to home* D. Ada hubungan family atau kerabat *there is a family relationship pr relatives* E. Bekerja sama dengan kantor/pabrik (jamsostek pabrik) *working closely with the office/factory (factory worker)* F. Murah *cheap* G. Gratis *free* H. Buka Sore hari *open afternoon* I. Buka 24 jam *open 24 hours* J. Pelayanan memuaskan (ramah, baik, nyaman) *satisfactory service (friendly, good, comfortable)* K. Lainnya Sebutkan, *Other Mention*_____	YA TDK A. .....1 .....0 B. .....1 .....0 C. .....1 .....0 D. E. .....1 .....0 F. .....1 .....0 G. .....1 .....0 H. .....1 .....0 I. .....1 .....0 J. .....1 .....0 K. .....1 .....0 L. 1 0	
G. PENANGANAN DIARE			
55	Apakah (NAMA) pernah sakit diare dalam **dua minggu terakhir**? *Has (name) had diarrhea in the past 2 weeks?* *RC q 34* BAB CAIR, LEBIH DARI TIGA KALI	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat don't remember.....9	☐**59** ☐**59**
56	Apakah (NAMA) diberikan cairan-cairan berikut ini sejak mulai diare? *Was s/he given any of the following to drink at any time since s/he started having diarrhea.* **BACAKAN DAFTAR JAWABANNYA.** JAWABAN BISA LEBIH DARI SATU		
	A. Cairan yang dibuat dengan melarutkan bubuk Oralit..... B. Bahan pengganti cairan yang sudah tersedia dalam bentuk cair..... C. Larutan gula garam yang disiapkan sendiri..... D. Cairan rumah tangga lainnya yang dibuat sendiri (teh, air tajin, dll).. E. ASI..... F. Lain-lain, sebutkan _____	YA TDK TDK TAHU A. ...1.....0.....9 B. ...1.....0.....9 C. ...1.....0.....9 D. ...1.....0.....9 E. ...1.....0.....9 F. ...1.....0.....9	
57	Selain itu, apakah (NAMA) mendapatkan obat yang lain untuk diarenya?	Ya *Yes*.....1	

	Other than that, was anything else given to treat the diarrhea? *RC q 36*	Tidak *No*..... 2 Tidak ingat don't remember.....9	☐**59** ☐**59**
58	Apa lagi yang diberikan untuk mengobati diare? *What else was given to treat diarrhea?* **BACAKAN DAFTAR JAWABANNYA.** JAWABAN BISA LEBIH DARI SATU. CATAT SEMUA JENIS PENGOBATAN		
	A. Antibiotika .... B. Antimotilitas/ anti diare .... C. Tablet Zinc .... D. Suntikan .... E. Infus melalui pembuluh darah..... ..... F. Obat buatan sendiri/jamu/obat tradisional..... ..... G. Lain-lain, sebutkan_____	YA TDK TDK INGAT A..... 1 ..... 0 ..... 9 B..... 1 ..... 0 ..... 9 C..... 1 ..... 0 ..... 9 D ..... 1 ..... 0 ..... 9 E..... 1 ..... 0 ..... 9 F..... 1 ..... 0 ..... 9 G ..... 1 ..... 0 9	
	H. ISPA/PNEUMONIA		
59	Apakah (NAMA) pernah sakit **batuk** dalam **dua minggu terakhir**? *Has (name) had a cough in the past 2 weeks?* *RC q 28*	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat don't remember.....9	 ☐**63** ☐**63**

60	Pada saat sakit batuk, apakah (NAMA) mengalami **sulit bernafas atau bernafas lebih cepat dari biasanya**? *When (name) was sick with a cough was it hard to breathe or did he/she breathe faster than usual?* *RC q 39*	Ya *Yes*.....1 Tidak *No*..... 2 Tidak ingat don't remember.....9	 ☐**63** ☐**63**
61	Apakah ibu mencari nasehat/Saran atau pengobatan saat (ANAK) mengalami batuk atau sulit bernapas? *Did you get advice or treatment when your child had a cough or had trouble breathing? RC 40*	Ya .....1 Tidak 2	☐**63**

62	Siapa yang memberikan nasehat/saran atau pengobatan tersebut? *Who gave the advice or treatment?* Siapa lagi? *Who else?* JAWABAN BISA LEBIH DARI SATU. **JANGAN DIBACAKAN.** TUNGGU JAWABAN SPONTAN IBU, JIKA IBU (SUDAH) DIAM TANYAKAN "ADA LAGI, BU?" CATAT SEMUA YANG DISEBUTKAN.		
	A. Dokter ..... B. Perawat ..... C. Bidan Puskesmas ..... D. Bidan swasta ..... E. Bidan desa ..... F. Nakes yang lain ..... G. Bidan Rumah sakit ..... H. Dukun ..... I. Kader ..... J. Keluarga/Teman ..... K. Lain-lain, sebutkan _____	YA TIDAK A ..... 1 ..... 0 B..... 1 ..... 0 C ..... 1 ..... 0 D ..... 1 ..... 0 E..... 1 ..... 0 F..... 1 ..... 0 G ..... 1 ..... 0 H ..... 1 ..... 0 I ..... 1..... 0 J..... 1..... 0 K..... 1..... 0	
	I. AIR DAN SANITASI		
63	Apa sumber utama **air minum** untuk keperluan anggota rumah tangga?	PAM .....1 Sumur gali terlindung (dengan cincin sumur).....2 Sumur gali tidak terlindung (tanpa cincin sumur).....3	

	PILIH SATU JAWABAN	Sumur bor .....4 Air dari truk .....5 Mata air terlindung .....6 Mata air tak terlindung.....7 Mengumpulkan air hujan.....8 Dari sungai/kolam/danau/waduk.....9 Air kemasan tersegel.....10 Air kemasan isi ulang .....11 Penjual air/pikulan/gerobak.....12 Lainnya (SEBUTKAN)_____99	
64	Apakah ibu melakukan sesuatu agar air tersebut aman untuk diminum? *Do you do anything to make your water safe to drink? RC q 42*	Ya .....1 Tidak 2	☐**66**
65	Jika ya, apa yang biasanya ibu lakukan untuk membuat air tersebut aman untuk diminum? *If yes, what do you do to make your water safe to drink? RC q 43* TUNGGU JAWABAN SPONTAN IBU. (CEK BILA TERDAPAT LEBIH DARI SATU JAWABAN, KARENA ADA BEBERAPA METODA YANG BIASANYA DIGUNAKAN SECARA BERSAMAAN, CONTOHNYA, SARINGAN KAIN DAN KLORIN)		

	YA	TIDAK
A. Dibiarkan hingga kotoran mengendap.....	A 1	0
B. Disaring dengan kain.....	B..... 1	0
C. Direbus	C 1	0
D. Diberi pemutih/klorin.....	D 1	0
E. Disaring (keramik, pasir, komposit).....	E..... 1	0
F. Solar Disinfection	F..... 1	0
G. Lain-lain, sebutkan_____	G 1	0
H. Tidak tahu.....	H 1	0

Cuci Tangan

66	Dapatkah ibu tunjukkan di mana ibu biasanya mencuci tangan? *Do you have a place where you usually wash your hands?* TANYAKAN APAKAH BOLEH UNTUK MELIHAT	Di dalam /dekat WC/kamar mandi.....1 Di dalam/dekat dapur/tempat masak.....2 Di halaman.....3 Di luar halaman.....4 Tidak ada tempat khusus.....5 Tidak diijinkan untuk melihat.....8	
67	Apa yang biasa ibu gunakan untuk mencuci tangan? JAWABAN HANYA SATU	Sabun.....1 Deterjen .....2 Debu .....3 Lumpur/pasir.....4 Tidak ada.....5 Lain-lain, sebutkan_____6	
68	**HANYA OBSERVASI**: APAKAH ADA SABUN ATAU DETERJEN ATAU BAHAN LAIN YANG DIGUNAKAN UNTUK CUCI TANGAN? *Observe: Is there soap or detergent or something else to wash hands?* BENDA/BARANG BISA TERDAPAT DI LOKASI ATAU RESPONDEN BISA LANGSUNG MEMPERLIHATKAN DALAM WAKTU 1 MENIT.	Sabun.....1 Deterjen .....2 Debu .....3 Lumpur/pasir.....4 Tidak ada.....5 Lain-lain, sebutkan_____6	

	JIKA BENDA/BARANGNYA TIDAK ADA DALAM WAKTU 1 MENIT ATAU DIBAWA LEBIH DARI 1 MENIT, TANDAI "TIDAK ADA".		
69	Apakah kemarin siang atau malam ibu menggunakan sabun? *Did you use soap yesterday during the day or night? RC q 46* **SELAIN MANDI DAN MENCUCI**	Ya ..... 1 Tidak 2	☐**71**
70	Untuk apa saja ibu menggunakan sabun kemarin siang atau malam? *What did you use soap for yesterday?* JIKA UNTUK MENCUCI TANGAN SENDIRI ATAU MENCUCI TANGAN ANAK DISEBUTKAN, TANYAKAN PADA SAAT APA SAJA IBU MENCUCI TANGAN, TAPI **JANGAN BACAKAN JAWABANNYA**. TANYAKAN "APA LAGI" SAMPAI TIDAK ADA JAWABAN LAGI YANG DISEBUTKAN DAN TANDAI SEMUA YANG SESUAI		
	A. Sebelum makan ..... B. Sebelum memberi makan anak..... C. Sebelum menyiapkan makanan ..... D. Setelah buang air besar ..... E. Setelah menceboki anak ..... F. Lain-lain, sebutkan _____	YA TIDAK A .....1 ..... 0 B .....1 ..... 0 C .....1 ..... 0 D .....1 ..... 0 E .....1 ..... 0 F 1 0	

	J. HIV/AIDS		
71	Apakah ibu pernah dengar tentang HIV atau AIDS?	Ya ..... 1 Tidak 2	☐**77**
72	Apakah ibu tahu tempat dimana masyarakat dapat memeriksakan diri apakah ia mendapatkan virus HIV atau penyakit AIDS? *Do you know of a place where people can go to get tested for the virus that causes AIDS?*	Ya ..... 1 Tidak 2	☐**74**
73	Dimana? *Where is that?* **PROBING UNTUK MENGIDENTIFIKASI JENIS TEMPATNYA DAN LINGKARI TEMPAT YANG DIMAKSUD. BILA TEMPAT PEMERIKSAAN DI RS, PUSAT PELAYANAN KESEHATAN, ATAU KLINIK, TULIS NAMA TEMPATNYA DI BAWAH INI** _____ (TEMPAT PEMERIKSAAN HIV DILAKUKAN). CATAT SEMUA SUMBER YANG DISEBUTKAN		

	Pelayanan Kesehatan Umum/Pemerintah A. RS pemerintah B. Puskesmas C. VCT center D. Klinik KB E. Mobil klinik F. Petugas Lapangan/Fieldworker **Pelayanan Kesehatan Swasta** G. RS/ Klinik/dokter swasta H. VCT center I. Apotik J. Mobil klinik K. Petugas Lapangan/Fieldworker L. Tempat umum swasta lain M. Tempat lainnya, sebutkan_____	YA TDK A .....1 ..... 0 B .....1 ..... 0 C .....1 ..... 0 D .....1 ..... 0 E .....1 ..... 0 F .....1 ..... 0 G .....1 ..... 0 H .....1 ..... 0 I .....1 .....0 J .....1 .....0 K .....1 .....0 L .....1 .....0 M 1 0	
74	Menurut ibu, apakah virus AIDS dapat ditularkan oleh ibu kepada bayinya? *Can the virus that causes AIDS be transmitted from a mother to her baby [Interviewer asks a-c]:* BACAKAN PILIHAN JAWABANNYA. JAWABAN BISA LEBIH DARI 1		
	A. Pada saat hamil . . B. Selama persalinan C. Melalui proses menyusui / pemberian ASI D. Lain-lain, sebutkan_____	YA TDK TDK TAHU A.....1 ..... 0 .....9 B.....1 ..... 0 .....9 C.....1 ..... 0 .....9 D.....1 ..... 0 9	
	CEK PERTANYAAN **NO 74** DI ATAS: JIKA SALAH SATU JAWABAN ADALAH **"YA"** (74a, 74b, ATAU 74c) → **NO. 75** JIKA SEMUA JAWABAN TIDAK/TIDAK TAHU → **K. ANTROPOMETRI**		
75	Apakah ada pengobatan khusus yang diberikan oleh dokter atau nakes kepada ibu hamil yang terinfeksi AIDS untuk menurunkan risiko penularan kepada bayinya? *Are there any special medicines that a doctor or nurse can give to a pregnant women infected with the AIDS virus to reduce the risk of transmission to her unborn baby?*	Ya *Yes*.....1 Tidak *No*..... 2 Tidak tahu *don't know*.....9	☐**77** ☐**77**
76	Apakah ibu tahu tempat dimana ibu hamil bisa mendapatkan obat khusus tersebut? *Do you know a place in the community where pregnant women can get this special medicine to reduce the risk of HIV transmission to her unborn child?*	Ya ..... 1 Tidak ..... 2 Tidak tahu..... 9	

K. ANTROPOMETRI			
MINTA IZIN KEPADA IBU UNTUK MENIMBANG BAYI/ANAKNYA. JIKA IBU SETUJU, CATAT INFORMASINYA PADA KOLOM DI BAWAH INI. JIKA IBU MENOLAK, BIARKAN KOLOM A - C KOSONG DAN CATAT **"3" (MENOLAK)** PADA KOLOM D. MINTA KEPADA IBU APAKAH ANDA BOLEH MENIMBANG SAUDARA (NAMA) YANG BERUMUR < 5 TAHUN, CATAT NAMA DAN PENGUKURANNYA DI BARIS PERTAMA.			
A **NAMA ANAK** TIMBANG (NAMA) TERLEBIH DULU, BARU KEMUDIAN TIMBANG SAUDARANYA YANG BERUMUR <5 TAHUN	B **TGL/BLN/TH LAHIR** CATAT TGL/BLN/TH LAHIR DARI KMS/KIA JIKA ADA. JIKA TIDAK TERSEDIA, CATAT INFORMASI YANG DIBERIKAN OLEH IBU.	C **BB (KILOGRAM)**	D **HASIL** 1. DIUKUR 2. TIDAK HADIR 3. MENOLAK 4. TIDUR
(77) Ibu dan anak termuda _____	_____/_____/_____	I: ..... II:	|___| _____
(78) Ibu saja _____	_____/_____/_____	I: ..... II:	|___| _____
(79) Ibu dan anaknya < 5 th _____	_____/_____/_____	I: ..... II:	|___| _____

Ucapkan terima kasih kepada Ibu atas wawancaranya

ANNEX VI – B. FINAL SBMR ASSESSMENT

Standards Based Management and Recognition

Adapted from the Maternal and Child Health Integrated Programs (MCHIP), the Standards Based Management and Recognition (SBMR) assessment tool was introduced to the West Jakarta Municipality Health Office in 2011. Since that time, Mercy Corps has included 40 private midwifes in West Jakarta in SBMR and through replication done by the West Jakarta Municipality Health Office in 2013 an additional 40 midwifes were included. The process involved the West Jakarta Midwives Association (IBI) and the Municipality Health Office personnel as the mentors for accessed midwifes.

The SBMR assessment process relies on self-reporting by health service providers (midwifes) on services provided and their compliance with the standards. The aim of the assessment is to gauge midwife performance and to take action to correct the gap between the standards and service provision. The assessment consists of nine tools containing standard indicators for maternal, newborn and infant services.

Targeted midwifes were introduced to the SBMR assessment process and the tools used to ascertain their compliance to the standards. The assessment tools were then distributed to each midwife to complete for their own score. Mentors then visited the midwife and re-assessed the applied compliance standard with the midwife and discussed the results in order to set the actual score based on "joint assessment".

The following 9 standards are applied in the SBMR.

1. Tool 1: Standard antenatal care 10 indicators
2. Tool 2: Standard normal delivery and newborn care 20 indicators
3. Tool 3: Standard post-partum and post-natal care 16 indicators
4. Tool 4: Standard management of complications during childbirth 12 indicators
5. Tool 5: Standard management of family planning 20 indicators
6. Tool 6: Standard management of family planning: pills and injection 7 indicators
7. Tool 7: Standard management of child immunization 5 indicators
8. Tool 8: standard for breastfeeding support 8 indicators
9. Tool 9: Standard for infection prevention 15 indicators

Mercy Corps Indonesia, the West Jakarta Municipality Health Office and the West Jakarta IBI conducted baseline and endline assessments of targeted midwives in West Jakarta throughout the implementation of the Hati Kami project (2011–2014). The baseline involved 40 private midwives and was conducted in September 2011 (for the first group) and March 2012 (for the second group.) The endline assessment for these midwives involved 25 midwives but only for indicators in Tools 1, 2, 3 and 8 since the indicators in these tools are the key program indicators for Hati Kami. A complete assessment of the nine tools will be conducted by the West Jakarta Municipality Health Office at a later date.

The results of the baseline and end-line SBMR assessment are shown in the following table.

Table 1:
SBMR Assessment Result

Tool No.	Tools	Number Indicator	Score 1	Score 2
1	Standard antenatal care	10	86.8%	92.4%
2	Standard normal delivery and newborn care	20	87.8%	96.8%
3	Standard post-partum and post-natal care	16	92.5%	98.3%
4	Standard management of complications during childbirth	12	86.3%	
5	Standard management of family planning	20	88.3%	
6	Standard management of family planning: pills and injection	7	87.9%	
7	Standard management of child immunization	5	90.7%	
8	standard for breastfeeding support	8	79.9%	93.0%
9	Standard for infection prevention	15	73.0%	
Total Score			**89.3%**	

10 Steps of Baby Friendly Protocol at Health Facility

The Ten Steps to Successful Breastfeeding assessment is used to assess the quality of a health service provider in supporting successful uptake of breastfeeding. This tool is designed to assess public health service providers in facilities such as: hospitals, Puskesmas (public health centers), and clinics. Hati Kami used this tool to assess the puskesmas in the intervention area. There are 20 facilities in the intervention area: 14 sub-district puskesmas, two district-level puskesmas and four hospitals. All of these health service facilities were assessed at the end of the program (August 2014). The assessment team consisted of Mercy Corps staff, IBI and the West Jakarta Municipality Health Office personnel.

The following ten indicators are used to assess if the health facility is supporting efforts for successful breastfeeding:

1	Have a written breastfeeding policy that is routinely communicated to all health care staff.
2	Train all health-care staff in the skills necessary to implement this policy.
3	Inform all pregnant women about the benefits and management of breastfeeding.
4	Help mothers initiate breastfeeding within an hour of birth. Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.
5	Show mothers how to breastfeed and how to maintain lactation, even if they should become separated from their infants.
6	Give infants no food or drink other than breastmilk unless medically indicated.
7	Practice rooming-in to allow mothers and infants to remain together 24 hours a day.
8	Encourage breastfeeding on demand. Teach mothers cue-based feeding regardless of feeding method.
9	Give no artificial nipples or pacifiers to breastfeeding infants.
10	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

The assessment team visited twenty health facilities and conducted a desk review of the available documents related to each of the indicators in the facility. Additionally, the team conducted key informant interviews in the respective hospitals and puskesmas. The following table shows the results of the health facility assessment:

Table 2:
Health Facility Assessment Results

No	Health Facility	Indicators										Total			%
		1	2	3	4	5	6	7	8	9	10	Y	T	Indicator Applied	
1	Cengkareng Barat 1	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
2	Cengkareng Barat 2	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
3	Rawa Buaya	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
4	Cengkareng Timur	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
5	Kapuk 1	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
6	Kapuk 2	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
7	Tegal Alur 1	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
8	Tegal Alur 2	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
9	Tegal Alur 3	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
10	Kamal 1	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
11	Kamal 2	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
12	Duri Kosambi 1	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
13	Duri Kosambi 2	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
14	Kedaung Kaliangke	T	Y	Y			Y		Y	Y	Y	6	1	7	85.7%
15	PKC Cengkareng	T	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	1	10	90.0%
16	PKC Kalideres	T	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	1	10	90.0%
17	RSU PIPI	Y	Y	Y	Y	Y	Y	Y	Y	Y	T	9	1	10	90.0%
18	RSUD Cengkareng	Y	T	Y	Y	Y	Y	Y	Y	Y	T	8	2	10	80.0%
19	RSU Tzu Chi	T	Y	Y	Y	Y	Y	T	Y	Y	Y	8	2	10	80.0%
20	RSIA Hermina	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	0	10	100.0%

Of the 10 indicators, three are not applicable for sub-district puskesmas since they are neither in-patient facilities nor do they provide birth services. The three indicators are:

4. Help mothers initiate breastfeeding within an hour of birth. Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.
5. Show mothers how to breastfeed and how to maintain lactation, even if they should become separated from their infants.
7. Practice rooming-in to allow mothers and infants to remain together (24 hours a day).

For the sub-district puskesmas, the denominator for the score is seven and for all other facilities the full ten indicators are used to sum the denominator for their score. All the puskesmas, one hospital and most of the facilities assessed by the team do not have a written breastfeeding policy that can be routinely communicated to all health care staff. Other indicators seem to be applied well by the health facility except indicator number 10 about fostering mother support groups.

For program indicator measurement purposes, both SBMR and health facility assessment tools are applied and the results are shown in the following table.

Table 3:
Indicator Result from SBMR and Health Facility Assessment

No	Health Service Providers Indicators	Tools	Baseline	Endline
1	Proportion of health service providers' compliance in giving standard antenatal care.	SBMR Tools 1 (all)	87.0%	90.0%
2	**Newborn services:** % health care providers who gave standard post natal check-ups	SBMR Tools 3 (all)	92.5%	98.3%
3	Proportion of health service providers' compliance in giving standard normal delivery and newborn care.	SBMR Tools 2 (all)	88.0%	96.8%
4	% health care providers who gave standard post- partum check-up	SBMR Tools 3 (all)	92.5%	98.3%
5	**Counseling services:** % health service providers who gave counseling on breastfeeding or maternal and infant care messages	SBMR Tools 8 (all)	79.9%	93.0%
6	**Baby Friendly Protocols:** % Health facilities that implemented at least 5 of the 10 steps to successful breastfeeding protocol	LMKM	n/a	100.0%
7	% health service providers who gave counseling on breastfeeding or maternal and infant care messages during ANC visits	SBMR Tools 1, (7.8.9)	93.0%	88.0%
8	% health service providers who gave counseling on breastfeeding or maternal and infant care messages during PNC visits	SBMR Tools 3 (14. 15.16)	97.6%	96.0%
9	% Health service providers who demonstrate sufficient capacity to counsel women during ANC or PNC visits	SBMR 1 (7.8.9) or SBMR Tools 3 (14.15.16)	97.6%	96.0%

ANNEX A: TOOLS FOR SBMR SURVEY

Tool 1: Standard antenatal care

1. Standard antenatal care
    a. Did the midwife have:
        i. 1.1.1 • Sphygmomanometers and stethoscopes
        ii. 1.1.2 • Fetoscope or Doppler
        iii. 1.1.3 • Thermometer
        iv. 1.1.4 • Tape measure
        v. 1.1.5 • Book Register / Mother cohort
        vi. 1.1.6 • MCH handbook
        vii. 1.1.7 • Gloves
        viii. 1.1.8 • Blankets
        ix. 1.1.9 • Clean bed to check the mother
2. Greets mother in a good, friendly fashion.
    a. During uptake does the midwife:
        i. 1.2.1 • Greet the mother and her family with a friendly greeting
        ii. 1.2.2 • Allow one of the family members in the room if the mother wishes
        iii. 1.2.3 • Explain to the mother and family what will be done
        iv. If they ask:
        v. 1.2.4 • Answer their questions clearly
        vi. 1.2.5 • Maintain the privacy of the mother
3. Midwives do assessment of data (if a new client create a new record for the mother; if old client, uses the old status of the mother and completes if not complete.
    a. The midwife asked and noted:
        i. 1.3.1 • The identity of the mother
    b. •History of pregnancy now:
        i. 1.3.2 - HPHT, record and calculate the gestational age of delivery
        ii. - Signs of danger and complication of pregnancy that is felt now
        iii. 1.3.3 * Vaginal bleeding
        iv. 1.3.4 * Difficulty in breathing
        v. 1.3.5 * Dizziness , blurred vision
        vi. 1.3.6 * Seizures / loss of consciousness
        vii. 1.3.7 * Edema hands and face
        viii. 1.3.8 * Fatigue , weakness , and fatigue
    c. -Another common complaint
        i. 1.3.9 - Drugs / herbs that were / are being consumed
        ii. 1.3.10 - Special Concerns
    d. • History of previous pregnancy, labor, childbirth:

i. 1.3.11 - The number of pregnancies, living children, premature birth
ii. 1.3.12 - Type of delivery (spontaneous, cesarean, forceps, vacuum
iii. 1.3.13 - Weight loss born baby, the baby's condition
iv. 1.3.14 - Complications of pregnancy / childbirth: hemorrhage, hypertension, fever etc.

e. • Diseases that are suffered / ever suffered ;
   i. 3.1.15 - Cardiovascular & Hypertension
   ii. 1.3.16 - Diabetes
   iii. 1.3.17 - Malaria
   iv. 1.3.18 - Sexually transmitted infections

f. • Socio-economic history :
   i. 1.3.19 - Marital status
   ii. 1.3.20 - Response mothers and families on pregnancy
   iii. 1.3.21 - Family support
   iv. 1.3.22 - Decision makers in the family
   v. 1.3.23 • Tetanus Toxoid Immunization Completeness

4. Midwives perform a physical examination correctly
   a. During the care of the pregnant mother does the midwife:
      i. 1.4.1 • Politely ask the mother to loosen clothes and cover the body not checked
      ii. 1.4.2 • Washing hands under running water, soap and dried with a towel personal / wipes.
      iii. 1.4.3 • Counting pulse
      iv. 1.4.4 • Measuring blood pressure
      v. 1.4.5 • Checking the conjunctiva
      vi. 1.4.6 • Checking breast
      vii. 1.4.7 • Checking for any enlargement of the thyroid gland and underarm
      viii. 1.4.8 • Check upper and lower extremities
5. Midwife obstetric examination correctly
   a. Did midwife do:
      i. 1.5.1 • Inspection of the abdomen ; (scar)
      ii. 1.5.2 • Measure the height of the fundus uteri
      iii. 1.5.3 • Determine the position of the baby (if the gestational age > 36 wks.)
      iv. 1.5.4 • Listen to DJJ
      v. 1.5.5 • Record all findings on the status of the card / ANC and MCH handbook
      vi. 1.5.6 • Tell the mother of all the findings
6. Tools and equipment are available for midwives to provide treatment correctly
   a. Do midwives do it right:

i. 1.6.1 • Provide immunization TT
ii. 1.6.2 • Provide Nutritional supplements : iron tablets , folic acid and calcium

7. Midwives do health education and counseling correctly
    a. Did midwife do:
        i. 1.7.1 • Health education / counseling
        ii. 1.7.2 • Calculating gestational age with her mother.
        iii. 1.7.3 • Overcoming discomfort that may arise
        iv. 1.7.4 • Meet the needs and address the problems presented with mom
        v. 1.7.5 • Explain the need for nutrition and the dangers of using drugs unnecessary.
        vi. 1.7.6 " • Explain the need for light exercise , rest , daily activities / work , and clothes
        vii. 1.7.7 • Discuss the personal and environmental hygiene
        viii. 1.7.8 • Preparation of exclusive breastfeeding
8. The midwife explained the danger signs of pregnancy with complete
    a. Did midwife explain:
        i. • Danger signs of pregnancy
            1. 1.8.1 - The presence of vaginal bleeding
            2. 1.8.2 - Difficulty in breathing
            3. 1.8.3 - Dizziness / blurred vision
            4. 1.8.4 - Stomach very pain / epigastric pain
            5. 1.8.5 - decreased consciousness / seizures
            6. 1.8.6 - hand and face edema
            7. 1.8.7 - irregular FHR / no sound
            8. 1.8.8 - reduced fetal movements / negative
            9. 1.8.9 - Spending vaginal / discharge
            10. 1.8.10 • Discuss contraception after childbirth
            11. 1.8.11 • Discuss sexual intercourse
9. Midwives assist mothers and their families to plan delivery
    a. Did midwives discuss with the mother:
        i. 1.9.1 • Who will help and encourage maternal labor in facilities health
        ii. 1.9.2 • Signs , symptoms of labor and when he had to call the midwife
        iii. 1.9.3 • Equipment that needs to be brought to the mother and baby
        iv. 1.9.4 • Transportation and funds required
        v. 1.9.5 • Blood Donors
        vi. 1.9.6 • Companion mother during childbirth
        vii. 1.9.7 • Decision makers in case of complications at home and a place of reference in the event of complications
10. Midwives reviewing / evaluating care and re- schedule the visit with the mother.

a. Did midwife do:
    i. 1.10.1 • Inform the examination results in the mother
    ii. 1.10.2 • Motivating mothers to ask and answer questions with obvious mother
    iii. 1.10.3 • Schedule a visit next birthday (second visit at 22-28 weeks gestation , 32 week of third pregnancy , and the fourth at 38 weeks gestation
    iv. 1.10.4 • Explain to the mother if the pregnancy period indicate a lack of abnormalities / symptoms of danger signs appear , the mother should immediately go to the nearest health care
    v. 1.10.5 • Record the entire results of the examination , diagnosis / problem and the care provided in
    vi. status of the mother / cards ANC and MCH handbook "
    vii. 1.10.6 • Say thank you to mother , that was willing to be examined and to remind further check on the schedule that has been discussed

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Tool 2: Standard normal delivery and newborn care

1. Midwife has the appropriate equipment for the provision of delivery care.
    a. Are the following tools available?
        i. 2.1.1 • sphygmomanometers and stethoscopes
        ii. 2.1.2 • fetoscope or Doppler
        iii. 2.1.3 • Thermometer
        iv. 2.1.4 • parturition sets
        v. 2.1.5 • Hecting set
        vi. 2.1.6 • Ambu bag or hood for babies
        vii. 2.1.7 • The vacuum lenders De Lee or bulb
        viii. 2.1.8 • Clamps or sterile umbilical cord thread
        ix. 2.1.9 • Bench place equipment
        x. 2.1.10 • Weighing the newborn
        xi. 2.1.11 • Hours
        xii. 2.1.12 • Bags of equipment
        xiii. 2.1.13 • Nelaton catheter
2. Available materials / supply of suitable and sufficient for the provision of delivery care
    a. Are the tools available below?
        i. 2.2.1 • Sterile Gloves / DTT
        ii. 2.2.2 • Gloves check
        iii. 2.2.3 • 2 pieces of fabric bedong clean to warm and dry the BBL
        iv. 2.2.4 • Kassa sterile to clean the face and mouth BBL
        v. 2.2.5 • Cotton and boiled water for cleaning the perineum

vi. 2.2.6 • syringes and disposable needles

3. The materials appropriate infection prevention prepared near the place of delivery.
    a. Are the following equipment available?
        i. 2.3.1 • Aprons plastic / rubber
        ii. 2.3.2 • Eye protection
        iii. 2.3.3 • rubber shoes with closed front
        iv. 2.3.4 • The hand towels
        v. 2.3.5 • Containers 05 % chlorine solution
        vi. 2.3.6 • Containers sharp tool
        vii. 2.3.7 • Plastic bags for trash
        viii. 2.3.8 • spray bottle or bowl containing 0.5 % chlorine solution
        ix. 2.3.9 • The placenta with a lid or a plastic bag to dispose of the placenta
4. Midwife has the proper equipment and appropriate medication available for the provision of routine care of pregnant women and delivery.
    a. Are the following equipment available?
        i. 2.4.1 • 6 amp Oxytocin (stored in a thermos cooler)
        ii. 2.4.2 • 2 pcs 5 ml Syringes
        iii. 2.4.3 • 5 pcs 3 ml Syringes
        iv. 2.4.4 • 3 amp Ergometrine
        v. 2.4.5 • 2 amp Lidocaine 1 %
        vi. 2.4.6 • 3 fls RL liquids and infusion devices
        vii. 2.4.7• 2 pcs Vitamin A
        viii. 2.4.8 • 1 pc antibiotic eye ointment for BBL
5. Equipment and supplies / materials to help resuscitate the new born baby prepared before delivery
    a. Are the following equipment available?
        i. 2.5.1 • Clock with second hand
        ii. 2.5.2 • De Lee suction mucus or rubber balls
        iii. 2.5.3 • Fume or ambu bag and mask.
6. Midwife serve mothers who want to give birth with a friendly and courteous attitude.
    a. Did midwife:
        i. 2.6.1 • Greet the mother and companion with a friendly and courteous
        ii. 2.6.2 * Answering a question with a language that is easily understood
        iii. 2.6.3 • Responsive to the needs of the mother at the time (thirst, hunger, feeling cold / hot, want to urinate, etc. . .)
7. Midwife assesses clinical history and filled the correct clinical history of mother who about to give birth.
    a. Did midwife:
        i. Ask the mother the following information?
            1. 2.7.1 - Name

2. 2.7.2 - Age
3. 2.7.3 - Number of previous births
4. 2.7.4 - Complications during labor and post-natal
5. 2.7.5 - The birth before the SC , forceps , or vacuum
6. 2.7.6 - Another common medical problem
7. 2.7.7 - Drugs used
8. 2.7.8 - Last Menstrual atauTanggal estimate of birth

ii. Ask the mother about the birth?

1. 2.7.10 - When to start feeling regular contractions that ache
2. 2.7.11 - How often do the contractions occur
3. 2.7.12 - If the mother's amniotic rupture : when, color , and what it smells like
4. 2.7.13 - Does the mother feel fetal movement
5. 2.7.14 • Record this information in the clinical records mother (SOAP format).

8. Midwife prepare for a physical examination correctly.
    a. Did midwife:
        i. 2.8.1 • Maintain the privacy of the mother
        ii. 2.8.2 • Explain to the mother and companion thing will be done by the midwife
        iii. 2.8.3 • Ask the mother to clean the bladder and the perineum is
        iv. 2.8.4 • Wash hands with soap and running water for 10-15 seconds and drying with a clean towel or with aerated
9. Midwife perform a physical examination correctly
    a. Verify if midwife:
        i. 2.9.1 • Explain each step of the examination to the mother
        ii. 2.9.2 • Measuring body temperature
        iii. 2.9.3 • Measuring the pulse
        iv. 2.9.4 • Measuring blood pressure
        v. 2.9.5 • Measure the height of the fundus uteri
        vi. 2.9.6 • Determine the location of the fetus
        vii. 2.9.7 • Identify the level of reduction in head by palpating the abdomen (from five to zero fingers above the pubis)
        viii. 2.9.8 • Evaluate uterine contractions (frequency and duration for 10 minutes)
        ix. 2.9.9 • Calculating the fetal heart rate (FHR)
        x. 9.2.10 • Explain all findings to the mother and companion
        xi. 9.2.11 • Record all findings into Partograph and status of the mother
10. Midwife examine in correctly.
    a. Did midwifes:

i. 2.10.1 • Explain to the mother what to do
ii. 2.10.2 • Wash hands with soap and running water for 10-15 seconds and then dried with a clean towel or dianginkan personal
iii. 2.10.3 • Wear gloves on both hands DTT
iv. 2.10.4 • Clean the perineum with warm boiled water
v. 2.10.5 • Carefully insert two fingers to check
vi. 2.10.6 • Assessing cervical dilatation , the magnitude of the opening , molasses , position / location of the lowest part
vii. 2.10.7 • Carefully pull the two fingers after the examination is completed
viii. 2.10.8 • Explain findings to the mother
ix. 2.10.9 • Remove gloves after dipped in 0.5 % chlorine solution and placed in a leak-proof container
x. 2:10:10 • Wash hands with soap and running water for 10-15 seconds and then dried with a clean towel or dianginkan
xi. 2:10:11 • Record all the information into the Partograph

11. Midwife prepares and implements the plan in accordance with the findings of the clinical history and physical examination, examination in obstetrics and to provide appropriate care to the mother.
    a. To mothers about to give birth, check if midwife:
        i. 2.11.1 • Ensure that the mother company of a companion on the first stage of labor
        ii. • Deliver to the mother about the importance of :
        iii. 2.11.2 - often to the bathroom so that the bladder is always empty
        iv. 2.11.3 - Drinking drinks and eating snacks whenever she had wanted
        v. 2.11.4 - Walking - roads and changing position according to the needs and comfort of the mother
12. Midwife uses Partograph to monitor labor and perform an appropriate birth plan when the mother enters the active stage of labor (4cm).
    a. Based on the clinical history and Partograph , check if whether midwife :
        i. Record information about the patient:
            1. 2.12.1 - Name
            2. 2.12.2 - Gravida , the
            3. 2.12.3 - The date and time of receipt of the midwife
            4. 2.12.4 - Time of the rupture of membranes
        ii. Every 30 minutes record:
            1. 2.12.5 - Fetus heart beat
            2. 2.12.6 - Uterine contractions (frequency and intensity for 10 minutes)
            3. 2.12.7 - maternal pulse
            4. 2.12.8 • Record temperature every 4 hours
            5. 2.12.9 • Record blood pressure every 4 hours

iii. At each examination (every 4 hours or less according to the progress of labor :
    1. 2:12:10 - Take note of the condition of the membranes and amniotic fluid characteristics
    2. 2:12:11 - Making molasses level head
    3. 2:12:12 - Noting cervical dilatation / size of the opening
    4. 2:12:13 - Creating images and fall head
    5. 2:12:14 • Record the amount of urine each time the mother BAK
    6. 2:12:15 • Record time (date and time) observations
iv. Adjust the birth plan appropriate to parameters found:
    1. 2:12:16 - If the normal parameters, implement the plan (free running, hydration, snacks if you want, change positions, etc. . .) OR
    2. 2:12:17 -If abnormal parameters , identify complications , diagnosis and adjust the recorded birth plan

13. Infection control practice during labor is done according to the standard.
    a. Assess whether at birth, the midwife:
        i. 2.13.1 • Using DTT or sterile gloves during the examination or when in contact with body fluids
        ii. 2.13.2 • To examine the finite (every four hours or when indicated)
    b. Emptying the bladder:
        i. 2.13.3 - The bladder should always refer mothers to empty the bladder frequently during persa l inan
        ii. 2.13.4 - Catheterization only performed if indicated; mother cannot urinate
        iii. 2.13.5 • Do not shave the perineal region
        iv. 2.13.6 • Do not split the amniotic
        v. 2.13.7 • Inform mother about the examination results
14. Midwife prepared to attend births.
    a. To mother who about to give birth and determine whether the Midwife (in the delivery room) :
        i. 2.14.1 • Observe and see the signs and symptoms of the second stage of labor
        ii. 2.14.2 • Ensure equipment , materials and drugs for resuscitation newborn labor and ready for use
        iii. 2.14.3 • Prepare yourself to deliver aid delivery
        iv. 2.14.4 • Ensure the fetal heart rate is still within the normal range
        v. 2.14.5 • Prepare the mother and family to assist in the guidance meneran
        vi. 2.14.6 • Maintain the cleanliness of the mother is
        vii. 2.14.7 • Explain to the mother how to help themselves and organize meneran process (when and how)

viii. 2.14.8 • Wear a clean apron made of plastic or rubber
ix. 2.14.9 • Wear eye protection
x. 2:14:10 • Wear shoes that protect the feet of the drip , splash or tools that fall
xi. 2:14:11 • Wash hands with soap and running water for 10-15 seconds and dry hands with a clean towel or dianginkan personal
xii. 2:14:12 • Wearing a glove on one hand DTT
xiii. 2:14:13 • Enter oxytocin into the syringe and put it in parturition sets / container DTT

15. Midwife have the proper equipment to help head birth correctly
    a. 2.15.1 • Perform check in to ensure complete opening
    b. 2.15.2 • Allowing the mother to meneran when mothers want to do (do not force the mother to Meneran)
    c. 2.15.3 • Explain to family members about how their role to support and encourage the mother to meneran correctly
    d. 2.15.4 • Helping birth in a position chosen by the mother
    e. 2.15.5 • An episiotomy is performed only if necessary (breech , shoulder dystocia , fetal distress)
    f. 2.15.6 • Ask the mother to gently meneran when contraction occurs when the head started to appear
    g. 2.15.7 • Placing the fingers of one hand on the baby's head to remain weak and to prevent the baby does not come out all of a sudden
16. Midwife helps birth correctly.
    a. Determine whether the midwife:
        i. 2.16.1 • After the head is born , the mother asked to stop
        ii. 2.16.2 • Wiping the baby's mouth and nose with sterile gauze (If there is meconium)
        iii. 2.16.3 • Perform palpation to determine whether the coiled cord in the neck
        iv. 2.16.4 • Leaving the pivot round out spontaneously without assistance
        v. 2.16.5 • Carefully put the baby's head in both hands and move his head towards the front of the shoulder down to appear below the pubic arch and move towards the top of the rear shoulder to give birth .
        vi. 2.16.6 • After the second birth shoulder, hand sliding towards the perineum mother to support the head, lower arm and elbow. Use hand over to browse and hold the upper arm and elbow
        vii. 2.16.7 • Search continues to hand over the back, buttocks, legs and feet. Grasp both ankles.
        viii. 2.16.8 • Putting the baby in a clean dry cloth on top of the stomach / abdomen mother and blanket

ix. 2.16.9 • Dry the baby until it is completely dry , then replace with a wet towel and a clean dry towel
x. 2:16:10 • If the baby is breathing normally , give the baby to the mother

17. Midwife performs AMTSL correctly.
    a. At the time of childbirth, determine whether midwife:
        i. 2.17.1 • palpating the maternal abdomen to make sure there are no second baby
        ii. 2.17.2 • Inform the mother that he would be injected , and inject 10 IU oxytocin IM
        iii. 2.17.3 • Clamp and cut the umbilical cord using sterile scissors and tying the umbilical cord.
        iv. 2.17.4 • Immediately for skin-to- skin contact between mother and baby and start breastfeeding early, put the baby on the mother's chest and let the baby looking for milk. Keep the baby's head is in the mother's breast with the lower position of the nipple.
        v. 2.17.5 • mother and baby blanket with a warm cloth / plug cap baby head
        vi. 2.17.6 • Placing one hand on the pubic symphysis mother over a clean towel
        vii. • 2.17.7 other hand tense cord and wait until the uterus to contract
        viii. 2.17.8 • When the uterus contracts , flex cord downwards while the other hand pushed towards the back of the dorso -cranial carefully , until the placenta is born
        ix. 2.17.9 • If the placenta is born after 30-40 seconds , stop and wait cord traction arise until the next contraction
        x. 2:17:10 • Perform tension and boost dorso - cranial to the placenta separates , the mother asked meneran while rescuers carry the cord with the direction parallel to the floor and then upward , following the axis of the birth canal (still do dorso -cranial)
        xi. 2:17:11 • If the umbilical cord is growing longer , move the clamp up is about 5-10 cm from the vulva and birth of the placenta
        xii. 2:17:12 • When the placenta appears at the vaginal introitus, born placenta with both hands. Hold and turn it until the membranes are twisted placenta later gave birth, uterine massage immediately do check both sides of the placenta while both the mother and the baby and ensure complete membranes , placenta intact and place it in the space provided .
        xiii. 2:17:13 • As soon as the placenta and the membranes were born , do massage uterus with a hands were covered with sterile cloth on the abdomen , with a circular motion until the uterus contracts (fundus palpable hard)

xiv. 2:17:14 • Perform necessary actions if the uterus does not contract after 15 seconds was massage

18. Midwife does proper postpartum care.
    a. At the time of childbirth , determine whether the Midwife (in the delivery room)
        i. 2.18.1 • Ensure that the uterus does not contract properly and vaginal bleeding
        ii. 2.18.2 • Help early initiation of breastfeeding and let the baby skin-to-skin contact on the mother's chest for at least 1 hour
        iii. 2.18.3 • Inform the mother what to do next , then carefully examine the vagina and perineum
        iv. 2.18.4 • Tailoring laceration if necessary.
        v. 2.18.5 • Removing the clamp and put in a container of chlorine 0.5 %
        vi. 2.18.6 • Clean and replace mothers clothes and fabrics.
        vii. 2.18.7 • Covering the perineum with a clean sanitary pad
        viii. 2.18.8 • Ensure that the mother feels comfortable (clean , drinking , and fabric-covered)
        ix. 2.18.9 • Ensure baby swaddled in cloth well , are in addition to the mother , and breastfed
        x. 2:18:10 • Teach mothers and families and recognize monitor uterine contractions.
19. Midwife placing used equipment and dispose of medical waste after attending births.
    a. Did midwife:
        i. Before removing gloves:
            1. 2.19.1 - Put placenta into a leak-proof container covered with plastic
            2. 2.19.2 - Disposing of medical waste (gauze, etc. . .) Into a plastic bag
            3. 2.19.3 - Putting a reusable equipment into a 0.5 % chlorine solution for 10 minutes
            4. 2.19.4 - The needle is inserted into the blackout to be burned at home or in health centers
            5. 2.19.5 - Cleaning Aprons with 0.5 % chlorine
            6. 2.19.6 • Remove gloves after dipped in 0.5 % chlorine solution
            7. 2.19.7 • Wash hands with soap and running water for 10-15 seconds and dried with a clean towel or aerated personal
20. Midwife carefully observing the mother and newborn for at least six hours after birth.
    a. Against the mother after birth, did midwife:
        i. • Monitor mother every 15 minutes during the first hour to check out :
            1. 2.20.1 - Uterine Contraction
            2. 2.20.2 - Vaginal Bleeding

3. 2.20.3 - full bladder
4. 2.20.4 Blood Pressure
5. 2.20.5 - The pulse
6. 2.20.6 - Awareness
7. 2.20.7 - Breath and the condition of the baby and breastfeeding

ii. • Monitor mother every 30 minutes in the second hour by checking :

1. 2.20.8 - Uterine Contraction
2. 2.20.9 - Vaginal Bleeding
3. 2:20:10 - a full bladder
4. 2:20:11 - Blood pressure and pulse rate
5. 2:20:12 - Hydration
6. 2:20:13 - Awareness
7. 2:20:14 - Breath and the condition of the baby and breastfeeding
8. 2:20:15 • Helping mothers breastfeed
9. 2:20:16 • Ask if the mother has been urinating and suggest mother to do so
10. 2:20:17 • And note all the information and abnormality found on maternal status and Partograph

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Tool 3: Standard post-partum and post-natal care

1. Midwife ready for mother and baby postpartum care
    a. Observe whether the midwife:
        i. • Prepare the necessary equipment
            1. 3.1.1 - Tensimeter
            2. 3.1.2 - Stethoscope
            3. 3.1.3 - Thermometers
            4. 3.1.4 - baby Scales
            5. 3.1.5 - Centimeters
            6. 3.1.6 - Gloves
            7. 3.1.7 - Cotton DTT for examination of the umbilical cord
            8. 3.1.8 - 0.5 % chlorine solution
            9. 3.1.9 - iron tablets , folic acid and vitamin A for Bufas
            10. 3.1.10 - infant immunization (Hep B)
            11. 3.1.11 - Status of mother and baby
            12. 3.1.12 • Greet the mother with respect and courtesy
            13. 3.1.13 • Inform the mother and her family, what will be done, listen to his curiosity and answer questions and concerns.
2. Midwife takes the mother's obstetric history

a. Did midwife ask the following (if the information is not already available in the status of the mother) :
    i. 3.2.2 • History of marriage
    ii. 3.2.3 • Availability of transportation
    iii. 3.2.4 • Availability of funds
    iv. 3.2.5 • The availability of donor blood
    v. 3.2.6 • Frequency of pregnancy and the number of children
    vi. 3.2.7 • The number of children living
    vii. 3.2.8 • Problem / complaint at this time
    viii. 3.2.9 • Maintenance / care provided by other health care worker / healer
3. Midwife performs a careful history of the birth.
    a. Did the midwife asked the mother:
        i. 3.3.1 • When the mother gave birth to his baby
        ii. 3.3.2 • Where she gave birth and who helped birth
        iii. 3.3.3 • What complications / complications during birth
        iv. 3.3.4 • Infant birth weight
        v. 3.3.5 • Are there any complications / complications with the baby
4. Midwife ready for post-partum care of mother and midwifery diagnose the state of maternal.
    a. Did midwife ask the following to the mother;
        i. 3.4.1 • The presence of severe bleeding from the birth of a baby
        ii. 3.4.2 • Color change in vaginal discharge and frequency of sanitary napkin / pants.
        iii. 3.4.3 • Are there any problems with urinating habits.
        iv. 3.4.4 • Get enough sleep / rest
        v. 3.4.5 • Normal Eating
        vi. 3.4.6 • maternal feelings towards the baby's presence and ability to care for her baby.
        vii. 3.4.7 • How does the family view of the baby's presence.
5. Midwife diagnoses the state of the baby
    a. Did midwife asked the following to mother
        i. 3.5.1 • Do you feel that the process of breastfeeding going well
        ii. 3.5.2 • Frequency of breastfeeding
        iii. 3.5.3 • The last time the baby is urinating and bowel movements as well as consistency , color
        iv. 3.5.4 • Are there current problems
        v. 3.5.5 • Immunizations are already given
        vi. 3.5.6 • Are given eye ointment
6. Midwife does a diagnosis of the need for contraception
    a. Did midwife asked the mother of the following:
        i. 3.6.1 • The number of children who planned / desired.

ii. 3.6.2 • Are already using the previous method of family planning.
iii. 3.6.3 • Are there any side effects of contraceptive use before
iv. 3.6.4 • Does she plan to use family planning methods in the future.

7. Midwife does disease history
    a. Does midwife ask the mother about;
        i. 3.7.1 • Is he allergic to something
        ii. 3.7.2 • Have chronic diseases such as tuberculosis , hepatitis , liver , diabetes or other chronic penalty
        iii. 3.7.3 • Never take medicine , including traditional medicine / local , herbs - vitamins and supplements
        iv. 3.7.4 • TT immunization (5 times) complete
        v. 3.7.5 • Last date gets a booster of tetanus toxoid
        vi. 3.7.6 • Are there any problems experienced today.
8. Midwife performs a physical examination - assessing the general condition of the mother
    a. Did midwife:
        i. 3.8.1 • Wash hands with soap and water, dry it with a personal towel / tissue or aerated.
        ii. 3.8.2 • Ask the mother to urinate / empty the bladder
        iii. 3.8.3 • Observe posture and movement, behavior and facial expressions.
        iv. 3.8.4 • Observe personal hygiene mother in general, the body odor.
        v. 3.8.5 • Checking whether pale conjunctiva
        vi. 3.8.6 • Asking is there any pain / discomfort
        vii. 3.8.7 • Ask the mother to bed and covered him.
9. Midwife checks vital signs
    a. Did midwife measure:
        i. 3.9.1 • maternal blood pressure
        ii. 3.9.2 • Breathing
        iii. 3.9.3 • The body temperature
        iv. 3.9.4 • Pulse
10. Ready for postpartum care
    a. Midwife examination mother breast, checks whether midwife :
        i. 3.10.1 • Explain step further physical examination and attention to maternal concerns.
        ii. 3.10.2 • Ask the mother to undress the top
        iii. 3.10.3 • Assessing the state of the breast swelling and abnormalities
11. Midwife performs an abdominal examination
    a. Did midwife:
        i. 3.11.1 • Ask the mother to undress the abdomen, legs slightly bent
        ii. 3.11.2 • View scar on abdomen
        iii. 3.11.3 • palpating the abdomen between the umbilicus and symphysis pubis
        iv. 3.11.4 • Record the size and magnitude of the uterus / involution
12. Did midwife do genital examination:
    a. 3.12.1 • Ask the mother opens the fabric for genital examination, with attention to privacy.
    b. 3.12.2 • Wash hands and wear gloves check / DTT in both hands.

c. 3.12.3 • Check the perineum
d. 3.12.4 • Record lochia color , smell and examine scars
e. 3.12.5 • decontaminate gloves before opening it and then soaking in 0.5 % chlorine solution
f. 3.12.6 • Wash hands with soap and water, dry it with a towel personal or aerated.
g. 3.12.7 • Help mother dressed again and sat in the chair provided.

13. Midwife performs a physical exam baby
    a. Did midwife:
        i. 3.13.1 • Put baby clean and warm place
        ii. 3.13.2 • Considering a baby
        iii. 3.13.3 • Measure the baby's body temperature and breathing
        iv. 3.13.4 • Observe skin color , movement / reflexes , tone
        v. 3.13.5 • Checking the head , face , mouth , and eyes
        vi. 3.13.6 • Examine the chest , abdomen , umbilical cord
        vii. 3.13.7 • Checking legs , arms , and back
        viii. 3.13.8 • Wash hands
14. Midwife assesses breastfeeding
    a. Observe whether the midwife:
        i. 3.14.1 • Helping mother breastfeed in a comfortable position
        ii. 3.14.2 • Help mother cleaning nipples before breastfeeding
        iii. • Help mother to position baby
        iv. 3.14.3 - Seeing how attached to the mother and the baby suck / suckle . Explained to the mother that she can say that her baby has been sucking / suckle properly
        v. 3.14.4 - If the baby is not attached or suckle properly , fix the position of the baby back .
        vi. 3.14.5 - Let the baby suckle as long as he wanted, until he let go of the nipple.
        vii. 3.14.6 - After feeding the baby Burp
15. Midwife provides advice to mother about breastfeeding and how to maintain health during nursing
    a. Does midwife suggest:
        i. 3.15.1 • Providing only breast milk during the first 6 months (exclusive breastfeeding)
        ii. 3.15.2 • Feed the baby as they wish
        iii. 3.15.3 • Change the position according to the comfort of the mother and baby
        iv. 3.15.4 • Get enough rest so that milk production is quite
        v. 3.15.5 • Eating and drinking one serving more than usual so that enough milk production .
        vi. 3.15.6 • Checking the sign that the baby is getting enough milk
        vii. 3.15.7 • Baby pees at least 6 times in 24 hours .
        viii. 3.15.8 • Birth weight gained after 1 week
        ix. 3.15.9 • Keep though nursing a sick baby
        x. 3:15:10 • Breastfeeding at least until the baby is two years old
16. Midwife provides health education and maternal care as needed

a. Did midwife:
    i. 3.16.1 • Reviewing mother returned preparedness plan in case of complications
    ii. 3.16.2 • Introduce the concept of family planning and spacing pregnancies
    iii. 3.16.3 • Provide advice and counseling and nutritional needs of the mother's diet
    iv. 3.16.4 • Provide advice and counseling on self-care
    v. 3.16.5 • Provide immunization against tetanus toxoid (TT) as scheduled
    vi. 3.16.6 • Provide iron / folate until the following visits and counseling needs of the way drinking and side effects ,
    vii. 3.16.7 • Provide other medications (such as Vitamin A) if it has not been given after birth
    viii. 3.16.8 • Schedule a visit the following
    ix. 3.16.9 • Say thank you for the visit to the mother's mother and asked if there were any questions to ask
    x. 3:16:10 • Record all care provided to mother and babies in the record visit / inspection
    xi. 3:16:11 • Wash hands with soap and running water and dry them

Tool 4: Standard management of complications during childbirth

1. Midwife mentions the steps that need to be in the resuscitation of newborn. Questions for Midwife: "what are the steps necessary to prepare resuscitation of newborn?"
    a. 4.1.1 • Prepare equipment and materials / supplies for resuscitation before helping each birth
    b. 4.1.2 • Immediately after birth, put the baby on the mother's abdomen. Wipe baby's entire body with cover cloth to dry and stimulate the baby
    c. 4.1.3 • If the baby does not start breathing spontaneously, cut the umbilical cord and put the baby into flat and hard
    d. 4.1.4 • Explain to the mother and her family that the baby needs help
    e. 4.1.5 • Remove wet clothes or towel.
    f. 4.1.6 • Quickly wrap the baby with a clean cloth, dry and warm without covering the baby's face
    g. 4.1.7 • Place your baby on his back with a cloth that is rolled up under his shoulders so that the head can be slightly raised.
    h. 4.1.8 • First do the suction in the mouth, then the nose.
2. Steps: Midwife mention the correct and technique for resuscitation of newborn baby.
    a. Questions for Midwife:" If the baby is still not breathing after inhaled mucus, what the next steps in the resuscitation baby? "
        i. 4.2.1 • If the baby is still not breathing, attach the hood / mask on baby's mouth and nose then ventilate twice
    b. • If the chest does not expand:

i. 4.2.2 - Check the position of the head.
ii. 4.2.3 - Check if the mask position and seal are correct.
iii. 4.2.4 - Check if there is fluid in the mouth. If there is, do suction.
iv. 4.2.5 • Perform ventilation in infants 20-30 times every 30 seconds. When babies start breathing, stop ventilation
v. 4.2.6 • Each finished the vents every 30 seconds, do a reassessment on respiratory baby
vi. 4.2.7 - If the baby is breathing spontaneously, stop resuscitation. Continue supporting care delivery.
vii. 4.2.8 - If the baby is not breathing or wheezing / gasping, continue ventilation 20-30 times every 30 seconds and then reevaluation.
viii. 4.2.9 • If the baby is still not breathing after resuscitation for 20 minutes, stop resuscitation and provide emotional support to the family

3. Midwife properly mention newborn care after resuscitation
    a. Question Midwife : "How do you provide care immediately after a successful resuscitation?"
        i. 4.3.1 • Stimulation baby gently to keep breathing.
        ii. 4.3.2 • If the breath / colors good baby, give the baby to the mother of a little baby stay warm and initiate early breastfeeding, so that milk may produce
        iii. 4.3.3 • Keep babies warm and dry. Wait for 24 hours before bathing the first time.
        iv. 4.3.4 • If the baby shows signs of danger, immediately refer to for special care
4. Midwife mention after-action task correctly
    a. Question for Midwife: "The task of what to do immediately after resuscitation"
        i. 4.4.1 • Soak suction catheter in 0.5% chlorine solution for 10 minutes for decontamination.
        ii. 4.4.2 • Clean the surface of the bag and mask were exposed to cotton that has been soaked in a solution of 60-90% alcohol or 0.5% chlorine solution, then rinsed immediately.
        iii. 4.4.3 • Wash hands thoroughly with soap and water, then dry with a clean cloth and dried (or aired)
    b. • Record the resuscitation efforts were made
        i. 4.4.4 - The condition of the baby at birth
        ii. 4.4.5 - Time / hours of the start of resuscitation
        iii. 4.4.6 - The steps performed (stimulation, ventilation)
        iv. 4.4.7 - Time / h baby can breathe normally OR when resuscitation is stopped

v. 4.4.8 - Results of resuscitation (successfully, it needs to be referred, the baby died)

5. Bimanual compression
    a. Midwife sets out the procedure correctly bimanual compression
        i. Question for Midwife : "What are the steps undertaken for bimanual compression":
            1. 4.5.1 • Provide emotional support and peace of continuously.
            2. 4.5.2 • Wear personal protective equipment
                a. • If you do not wear gloves, wear gloves or surgical gloves DTT sterile
            3. 4.5.3 • First input obstetric fingers into the vagina and make a fist with the hand, found anterior fornix and apply pressure on the anterior wall of the uterus.
            4. 4.5.4 • Place your other hand on the abdomen behind the uterus, press the hand on the abdomen and apply pressure on the posterior wall of the uterus.
            5. 4.5.5 • Maintain compression until bleeding can be controlled and the uterus to contract.
6. Midwife mentions task / action step to the right post
    a. Question for Midwife : "What are the steps after action taken after bimanual compression?"
        i. 4.6.1 • Remove gloves and throw it into a leak-proof container or plastic bag if it will be disposed of, or decontaminated in 0.5% chlorine solution if it will be reused.
        ii. 4.6.2 • Wash hands until it is completely clean.
        iii. 4.6.3 • Monitor vaginal bleeding, recorded vital signs and make sure that the uterus has contracted with strong.
7. Placenta issued manually
    a. Midwife said it right preparation to remove the placenta manually
        i. Question for the Midwife, "What steps should be taken to remove the placenta manually:"
            1. 4.7.1 • Prepare the necessary tools.
            2. 4.7.2 • Inform the mother about what will be done, listen attentively and answer the questions and concerns of the mother.
            3. 4.7.3 • Providing emotional support and confidence continuously.
            4. 4.7.4 • Ask the mother to empty the bladder or catheter plug.
8. The midwife said step needed for njlasewborn resuscitation
    a. Manual removal of placenta correctly.
        i. "Questions for Midwife," What are the steps to manually remove the placenta? "

1. 4.8.1 • Wear personal protective equipment
2. 4.8.2 • Wash hands and arms thoroughly then put on sterile surgical gloves / long gloves (be sure to wear protective elbow).
3. 4.8.3 • Hold the umbilical cord with clamps and stretched carefully.
4. 4.8.4 • Place the fingers of one hand into the uterine cavity by tracing the search for the placenta umbilical cord that has been separated.
5. 4.8.5 • Holding the uterine fundus with the left hand.
6. 4.8.6 • Move the hand combing the edge of the placenta that has separated with gentle movements same direction until the entire placenta separates from the uterine wall
7. 4.8.7 • Pull hand from the uterus, bring placenta while continuing to provide traction against in the abdomen
8. 4.8.8 • Give oxytocin in intravenous fluids.
9. 4.8.9 • Requesting / mother teaches families to massage fundus to stimulate uterine contractions.
10. 4.8.10 • If the heavy bleeding continues to occur, given repeated injections of oxytocin IM and prepare for referral
11. 4.8.11 • Check the surface of the placenta separated from the uterus to ensure that the placenta has complete.
12. 4.8.12 • Check the condition of the mother carefully and fix the cervix and vaginal tearing or episiotomy stitches do repairs.

9. "The midwife mention the right steps that needed to be taken for resuscitation measures necessary after the placenta removed
    a. "Questions for Midwife:" What are the steps to be taken after the placenta is delivered? "
        i. 4.9.1 • Remove gloves and throw it into a leak-proof container or plastic bag if it will be disposed of, or decontaminated in 0.5% chlorine solution if it will be reused.
        ii. 4.9.2 • Wash hands until it is completely clean.
        iii. 4.9.3 • Monitor vaginal bleeding, recorded vital signs and make sure that the uterus has contracted with strong.
10. Referral preparation
    a. Midwife mentions the steps that need to be in the referral.
        i. Questions for Midwife any steps to refer:
        ii. 4.10.1 • Mention refer Preparation (BAKSOKU)
        iii. 4.10.2 • Inform family
        iv. 4.10.3 • Evaluate the state of the patient as a whole
        v. 4.10.4 • Identify actions to perform basic first aid.

11. Midwife mentions preparation and other tools to refer clients preparation tools:
    a. 4.11.1 • Gloves DTT / Sterile
    b. 4.11.2 • Gauze / plaster / scissors
    c. 4.11.3 • Set parturition
    d. 4.11.4 • Tampons
    e. 4.11.5 • Tensimeter
    f. 4.11.6 • Stethoscope
    g. 4.11.7 • fetoscope / Doppler
    h. 4.11.8 • Liquid NaCl 0.9% + Ringer Lactate 4 pieces
    i. 4.11.9 • Abbocath No. 18/2 pieces
        i. • Infusion Macro 4:11:10 2 pieces
        ii. • Oxytocin Injection 4:11:11 6 ampoule
    j. 4:11:12 • injection of 2 ampoule Metergin
    k. 4:11:13 • Syringe 3 cc of 2 pieces
    l. Preparation of referral transport:
        i. 4:11:14 • vehicle and driver
    m. Mail Preparation:
        i. • Letter of approval families 4:11:15
        ii. 4:11:16 • Partograph
        iii. 4:11:17 • Referral Letter of midwife / doctor of health center
    n. 4:11:18 Readiness patients:
        i. 4:11:19 • Support the patient's mental
        ii. 4:11:20 • Preparation of funds
        iii. 4:11:21 • Preparation of blood donors
12. Midwifery Management
    a. The infusion procedure before performing the action (just before referring / journey or shortly arrive at a place of reference);
        i. 4.12.1 • Tells what will be done to the patient
        ii. 4.12.2 • Adjust the position of the patient
            1. • Describe the purpose 4.12.3 infusion
            2. • Wash hands 4.12.4 Effective
            3. • Determine and agree 4.12.5 infusion area
        iii. 4.12.6 • Install a drip hose on intravenous fluids, air controls, further depends on the standard infusion
        iv. 4.12.7 • Ensuring open the patient's clothing, if not able to open release, keep the patient privacy.
        v. 4.12.8 • Post tourniquet and ask the patient clenched her fingers
        vi. 4.12.9 • Perform disinfection of water at the point of injection with DTT by means of a circular exit with a diameter of 5 cm.
        vii. 4:12:10 • Stick Intravenous Catheter with needle holes facing up.

viii. 4:12:11 • Make sure that the needle enters the vein by pulling mandrin facing up.
ix. 4:12:12 • Connect the catheter to the intravenous drip hose.
x. 4:12:13 • Make sure the liquid gets smoothly, do fixation on the needle and IV line.
xi. 4:12:14 • Disinfectants point injections with betadine
xii. 4:12:15 • Cover with sterile gauze
xiii. 4:12:16 • Cover with a plaster and record the date and hour infusion
xiv. 4:12:17 • Set the number of droplets as recommended by your doctor.
xv. 4:12:18 • Observation of the patient's reaction.
xvi. 4:12:19 • Clearing tools.
xvii. 4:12:20 • Wash hands effective again.

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Tool 5: Standard management of family planning

1. Mother in greetings with good and friendly.
    a. During care whether Midwife do:
        i. 5.1.1 • Greet the mother and her family with a friendly
        ii. 5.1.2 • Allow one of the families in the room as you wish mom
        iii. 5.1.3 • Ask the mother / companion and expressed his wish to ask
        iv. 5.1.4 • Answer their questions clearly
        v. 5.1.5 • Ensure client confidentiality
        vi. 5.1.6 • Provide privacy during visits to close the door / Curtain
2. Midwife do diagnose and care During data entry midwife asked and noted:
    a. 5.2.1 • The identity of the mother: name, age, address
    b. 5.2.2 • Asks client about reproductive purposes and the need for contraception
3. Mother politely greeted, midwife provide information friendly. complete about contraceptive methods available and ensuring client choice
    a. "Do Midwife do:
        i. 5.3.1 • Asking if the client is interested in a particular contraceptive method
        ii. 5.3.2 • Inform other methods are available and provide appropriate information of interest with her mother and family
        iii. 5.3.3 • Describe methods of contraception that the client wants or help choose a suitable contraceptive
        iv. 5.3.4 • Using visual aids including examples of contraception during the consultation
        v. 5.3.5 • Describe methods of lactation amenorrhea
        vi. 5.3.6 • Use language that is easily understood by the client
        vii. 5.3.7 • Ensure that the client has chosen contraceptive method
4. Midwife ensure clients are not pregnant Are Midwife to ensure the client is not pregnant:

a. 5.4.1 • Explain the importance of ensuring that the client is not pregnant
b. 5.4.2 • Ensure that the client within 7 days of the menstrual period
c. 5.4.3 • If the client is not within the first 7 days of menstruation, make sure not pregnant, with:
d. 5.4.4 • Do not have sex after the last menstrual period OR
e. 5.4.5 • Using effective contraception OR
f. 5.4.6 • Still within 4 weeks postpartum OR
g. 5.4.7 • Still in the past 7 days post-abortion OR
h. 5.4.8 • Breastfeeding in full / exclusive and are in the post-partum period is less than 6 months, and have not yet menstruated
i. 5.4.9 • Negative pregnancy test
j. 5.4.10 • Knowing that, if the client has produced more than 6 months ago and has not gotten her period, chances are she is not pregnant, if:
k. 5.4.11 - Very often breastfeeding
l. 5.4.12 - No signs or symptoms of pregnancy

5. Midwife provide a description of the protection against STDs, including HIV / AIDS
    a. Did Midwife do the following:
        i. • Describe the risk factors for contracting the infection STD / HIV / AIDS and its symptoms al:
            1. 5.5.1 • Having more than one partner or multiple partners
            2. 5.5.2 • There were complaints / pain when urinating.
            3. 5.5.3 • There are symptoms of vaginal discharge that is cloudy / smelly / itchy.
            4. 5.5.4 • There are sores on the genitals that do not heal.
            5. 5.5.5 • Explain that current contraceptive that can provide protection against STDs / HIV / AIDS only condoms
            6. 5.5.6 • Explain that if someone is no risk of contracting / transmitting infections STD / HIV / AIDS, should use condoms, in addition to family planning methods to be used (Dual Protection)
            7. 5.5.7 • Answering client questions regarding STD / HIV / AIDS
6. When clients choose to use oral contraceptives as a method of contraception that will be used.
    a. Midwife ensure PIL KB COMBINATION according to the client's condition)
        i. Did Midwife:
            1. 5.6.1 • receipts WHO medical eligibility criteria to decide whether birth control pills according to client circumstances Checking the health condition of the client which can be a problem for the Pill
            2. 5.6.2 • If the mother's health condition does not match, the midwife explained that contraception is appropriate and help the client choose another method.

7. "Mom greeted with kind and friendly.
    a. Midwife provide information, specifically about contraception
        i. PIL COMBINATION "
            1. Did Midwife:
                a. 5.7.1 • Using visual aids, briefly explain the essential characteristics of Combination Pills
                b. 5.7.2 • Type: There are several brands with a slightly different dose
                c. 5.7.3 • Effectiveness: That pill is very effective when taken daily
                d. 5.7.4 • How to pills to prevent pregnancy: Suppress ovulation and thicken cervical fluid other than other changes in the genital tract
                e. 5.7.5 • How to use the pill: a pill every day, is recommended at the same time
                f. 5.7.6 • Take the first pill between the first and seventh day of the menstrual period (first day is better)
                g. 5.7.7 • When starting after the seventh day, use a backup method or do not have sex for 1 week
                h. 5.7.8 • Starting a new package immediately (the next day) after spending the previous package
                i. 5.7.9 • Explain the common side effects:
                j. 5.7.10 • May cause nausea, dizziness, breast pain, headache, weight na ik / tu run
                k. 5.7.11 • May cause bleeding or spotting between menstrual periods or no menstrual
                l. 5.7.12 • Side effects usually disappear after 2 or 3 cycles
                m. 5.7.13 • Things to do in the event; diarrhea or vomiting (minimum 24 hours) → use a backup method (condoms) for at least 7 days
                n. 5.7.14 • The thing to do when late menstrual period → 2 or more to come to the clinic / midwife
                o. 5.7.15 • If you forget to take the pills; if only forgot 1 pill, take the pill as soon as remembered (even may take 2 pills in one day), If you forget 2 pills, take 2 pills a day until overtaken deficiency and use a backup method (condoms) or avoid sex for 7 days.
8. Signs of complications midwife explains the use of the method selected PIL
    a. Did midwife explain that the client should immediately report to the midwife / clinic when experiencing signs - signs of complications:

i. 5.8.1 • Severe pain in the lower abdomen or pelvis
ii. 5.8.2 • Chest pain is great
iii. 5.8.3 • Pain in the feet that great
iv. 5.8.4 • severe headache
v. 5.8.5 • Bleeding that many

9. Midwife provides appropriate birth control pills
    a. 5.9.1 Are Midwife provide appropriate
10. If the client chooses to use as a method of family planning contraceptive injections
    a. Midwife describes COMBINED INJECTABLE KB and to watch out for in use (If this method is chosen and appropriate for the client)
        i. Did Midwife:
            1. 5.10.1 • menggunakkan medical persaratan WHO criteria to decide whether birth control pills according to client circumstances.
            2. 5.10.2 • Checking the client's health condition that can be a problem for the Pill
            3. 5.10.3 • If the mother's health condition does not match, the midwife explained that contraception is appropriate and help the client choose another method.
11. Mother greeted with a nice and friendly.
    a. Midwife provides information on relevant specific KB INJECTION COMBINED.
        i. 5.11.1 • Using visual aids, briefly explain the essential characteristics of injection KB Combination
        ii. 5.11.2 • Type: Cyclofem or CycloGeston (DPMA and estradiol cypionate)
        iii. 5.11.3 • Effectiveness: Very effective when used every month (<1 pregnancy per 100 women during the first year of use)
        iv. 5.11.4 • How to prevent pregnancy injectable drugs: inhibit ovulation and thicken cervical mucus in addition to some other changes in the genital tract
        v. 5.11.5 • How to use: one injection every month
        vi. 5.11.6 • Common side effects:
        vii. 5.11.7 • Can cause changes in menstrual pattern (irregular / spotting or amenorrhea) in some women.
        viii. 5.11.8 • May cause nausea, dizziness, breast pain, headache, weight na ik / tu run
        ix. 5.11.9 • These side effects usually go away after 2 or 3 injections
12. Midwife provides an explanation on how to use family planning methods Injectable Combination
    a. Did Midwife do:
        i. • Explain how giving injections:

1. 5.12.1 • Provide first injection between days 1 and 7 to the menstrual period
2. 5.12.2 • If started after day 7, use a backup method (condoms) or avoid sex for 1 week
3. 5.12.3 • Return to the clinic to get a shot every 30 days
4. 5.12.4 • Can be returned 3 days earlier / later for the next injection
5. 5.12.5 • Explain things to do when the next injection is given after the 3 days (con dom use, other contraceptive methods or avoid sex until received injections KB again.

13. Family Planning. Midwife describes progestin injections and to watch out for in use (If this method is chosen and appropriate for the client)
    a. Did Midwife:
        i. 5.13.1 • Megunakkan medical persaratan WHO criteria for deciding whether injectable progestins according to the state of the client
        ii. 5.13.2 • If the mother's health condition does not match, the midwife explained that contraception is appropriate and help the client choose another method.
14. Midwife provides specific information about the relevant KB progestin injections.
    a. Did Midwife:
        i. 5.14.1 • Using visual aids, briefly describes the important characteristics of progestins Injection KB
        ii. 5.14.2 - Type: Injection every 2 months; Net-En (Noristerat) or injections every 3 months (Depo - Provera, DepoGeston, Depo - Progestin)
        iii. 5.14.3 - Effectiveness: Very effective (<1 pregnancy per 100 women during the first year of use) and immediately effective
        iv. 5.14.4 • How it works injectable contraceptives: cervical mucus to thicken so as to prevent the penetration of sperm, endometrial change, there is resistance at ovulation
        v. 5.14.5 • How to use: one injection every 2 months (NetEN) and 3 months for DMPA
    b. • Common side effects:
        i. 5.14.6 - Can cause changes in menstrual pattern, bleeding / spotting between periods irregular menstruation or amenorrhea (more frequent with DMPA)
        ii. 5.14.7 • menstrual changes usually begin after 2-3 injections and 50% of the users do not get the bleeding until the end of the first year
        iii. 5.14.8 • May cause weight gain (specifically its DPMA)
        iv. 5.14.9 • May cause nausea, dizziness, breast pain, headache, mood changes
        v. 5:14:10 • Can delay the return of fertility (6-12 months)

15. Midwife provides an explanation on how to use the method
    a. Did Midwife:
    b. 5.15.1 • Explains how the injection and what influence
    c. 5.15.2 • Provide first injection between days 1 and 7 of the menstrual period
    d. 5.15.3 • When giving injections started after day 7, use a backup method (condoms) or avoid sex for 1 week
    e. 5.15.4 • Explain to come back for injections every 2 months (NetEN) or 3 months (DMPA)
    f. 5.15.5 • Explain that the client can return 2 weeks (NetEN) or 4 weeks (DMPA) earlier / later for the next injection
16. Signs of complications midwife explains the use of the method selected INJECTION
    a. Did Midwife explain the following things, and when it occurs immediately reported to the midwife or health center:
        i. 5.16.1 • Severe pain in the lower abdomen or pelvis
        ii. 5.16.2 • Chest pain is great
        iii. 5.16.3 • Pain in the feet that great
        iv. 5.16.4 • severe headache
        v. 5.16.5 • Blood or Pus place the injection
        vi. 5.16.6 • Bleeding many
17. Midwife prepares the necessary equipment for injections
    a. What Midwife do the following:
        i. 5.17.1 • Prepare a sterile syringe from the open front wrap client and put in sterile containers
        ii. 5.17.2 • Check the expiration date of injecting drug
        iii. 5.17.3 • Wash hands with soap and running water and drying with a towel personal or aerated.
        iv. 5.17.4 • Describe the actions that will be performed on the client
18. Midwife does injections correctly and appropriately
    a. Did Midwife do:
        i. 5.18.1 • Shuffle the drug vial gently to evenly
        ii. 5.18.2 • Unscrew the vial without touching the rubber cap
        iii. 5.18.3 • needle into the rubber cap vial, invert the vial and suck the liquid into the syringe
        iv. 5.18.4 • Hold the pre-filled syringe, with the needle upwards and remove the air with the pusher
        v. 5.18.5 • thrust the needle into the muscle (deltoid area of the arm or upper quadrant, outer buttocks)
        vi. 5.18.6 • Pull back the plunger (aspiration)
        vii. 5.18.7 • When no bloody, inject and withdraw the needle slowly fluid
        viii. 5.18.8 • Pressing the injection site with cotton, but NOT rub

19. Midwife discards syringes improperly
    a. Did Midwife do the following;
        i. 5.19.1 • Discard needle and syringe into the needle does not penetrate, without removing, closing, or break needles
        ii. 5.19.2 • Wash hands with soap and running water and drying hands with a personal towel / tissue or aerated.
20. Midwife memberiakan landing on repeat visits or follow-up
    a. Did Midwife:
        i. 5.20.1 • Discuss visits and re-follow-up
        ii. 5.20.2 • Ask the client to repeat the possible side effects and signs of complications and what to do
        iii. 5.20.3 • Encourage the client to return anytime if you have questions or problems
        iv. 5.20.4 • Provide the card acceptor (notes) that have been re-written with the date of the visit to the client
        v. 5.20.5 • Saying goodbye politely
        vi. 5.20.6 • Complete the medical records of clients

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Tool 6: Standard management of family planning: pills and injection

1. Mother greeted with a nice and friendly.
    a. During care whether midwives do:
        i. 6.1.1 • Greet the mother and her family with a friendly
        ii. 6.1.2 • Allow one of the families in the room as you wish mom
        iii. 6.1.3 • Ask the mother / companion and expressed his wish to ask
        iv. 6.1.4 • Answer their questions clearly
        v. 6.1.5 • Ensure client confidentiality
        vi. 6.1.6 • Provide privacy during visits to close the door
2. Midwives use interpersonal communication skills during the visit
    a. Did midwives:
        i. 6.2.1 • Encourage the client to ask
        ii. 6.2.2 • Answering client's questions and concerns
        iii. 6.2.3 • Using a variety of techniques hearing and asked (e.g. open-ended questions)
        iv. 6.2.4 • Conduct face-to-face
        v. 6.2.5. Using non-verbal communication-friendly (e.g. smiling)
        vi. 6.2.6 • Using language that is easy to understand
        vii. 6.2.7 • Using the tool if necessary
        viii. 6.2.8 • Summarize issues client when necessary
        ix. 6.2.9 • Provide opportunities for the client to repeat the information to ensure that it understand.

3. Midwives ask client satisfaction of methods used
    a. Did midwives do:
        i. 6.3.1 • Confirm the type of combination contraceptives in use today
        ii. 6.3.2 • Asking if the client is satisfied with contraception or when a client wants to
    b. If the client is not satisfied with the current contraception and want to stop or do not use it anymore
        i. 6.4.1 • Help clients choose other contraceptive
        ii. 6.4.2 • Asking if the client requires Alkon while until he can start using the new contraceptive
4. Midwife identified side effects or problems experienced with combination contraception
    a. Did midwife do the following:
        i. 6.4.1 • Explain to the client the importance of health check to ensure that she can continue to use contraception safely
        ii. 6.4.2 • Asking if the client is experiencing side effects or problems with contraception
        iii. 6.4.3 • Ask to identify adverse events and / or problems experienced by the client if any.
        iv. 6.4.4 • Studying the client's medical record to check if there is a medical condition that needs to be in watch out for the use of current contraceptive
        v. 6.4.5 • Perform pelvic examination if necessary (with a speculum and bimanual)
5. Midwives provide a description of the protection against STDs, including HIV / AIDS Is a midwife:
    a. • Describe the risk factors for contracting the infection STD / HIV / AIDS and symptoms include:
    b. 6.5.1 • Having more than one partner or multiple partners
    c. 6.5.2 • There were complaints / pain when urinating.
    d. 6.5.3 • There are symptoms of vaginal discharge that is cloudy / smelly / itchy.
    e. 6.5.4 • There are sores on the genitals that do not heal
    f. 6.5.5 • Explain that current contraceptive that can provide protection against STDs / HIV / AIDS only condoms
    g. 6.5.6 • Explain that if someone is no risk of contracting / transmitting infections STD / HIV / AIDS, should use condoms, in addition to family planning methods to be used (Dual Protection)
    h. 6.5.7 • Answering client questions regarding STD / HIV / AIDS
6. Midwife verifies instructions on how to use contraceptives when using the combination pill:
    a. * Ask the client how to use the pill, by asking the client to tell:
        i. 6.6.1 * The way the client to take the pills

ii. 6.6.2 * What to do when diarrhea or vomiting
iii. 6.6.3 * What to do when a late period 2 months or more
iv. 6.6.4 * What to do when forgot to take the pill

b. When using Injectable combination:
   i. 6.6.5 * Ask how to use the injection method; when he should come to the next injection
   ii. 6.6.6 * What to do when he is late for more than 3 days following injection (Clients should know that he should wear a condom as a substitute until she gets the next injection)

c. • For both methods above:
   i. 6.6.7 • Correcting or add information if necessary

7. Midwives give hints on repeat visits or follow-up is necessary to use a contraceptive method
   a. Did midwife:
      i. 6.7.1 • Discussing re-visit and follow-up
      ii. 6.7.2 • Repeating danger signs / complications
      iii. 6.7.3 • Convincing again that the client can stop using contraception is being used and choose another contraceptive whenever he wants
      iv. 6.7.4 • Encourage clients to come back at any time when he has a question or problem
      v. 6.7.5 • Ask the client if there are questions or concerns
      vi. 6.7.6 • Answering client questions
      vii. 6.7.7 • Saying good-bye and thank you to mother politely
      viii. 6.7.8 • Complete medical records of clients

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Tool 7: Standard management of child immunization

1. There is a register / log for immunization services
   a. Were:
      i. 7.1.1 • Midwife record the name, age and address for each patient
      ii. 7.1.2 • Midwife verify the immunization status of mothers with immunization card check.
   b. • The midwife checked the immunization schedule by age of the child and determine appropriate immunizations during this visit
      i. 7.1.3 - HepB Uniject 0-7 days
      ii. 7.1.4 - BCG and Polio 1, 2-4 mg
      iii. 7.1.5 - DPT1, HepB1 and Polio 2, 2 months
      iv. 7.1.6 - DPT2, HepB2 and Polio 3, 3 months
      v. 7.1.7 - DPT3, Polio HepB3 and 4, 4 months
      vi. 7.1.8 - Measles at month 9

2. Counseling on child immunization conducted
    a. Did midwife
        i. 7.2.1 • Ask if the client bring the immunization card / KIA book which is true if yes, thank you. If not, provide information about the importance of the card
        ii. 7.2.2 • Explain the reasons for immunization
        iii. 7.2.3 • Explain the importance of getting all the proper immunizations cycle
        iv. 7.2.4 • Explain the possible side effects and how to cope with pain, fever, etc.. in children under five
        v. 7.2.5 • Explain when to return for the next immunization
3. Immunization of children is given by injection
    a. Did midwife
        i. 7.3.1 • Washing hands with water and soap and dry hands or use alternative hand washing
        ii. 7.3.2 • Explain to the mother or caregiver on how to carry a child
        iii. 7.3.3 • Explain to the mother or caregiver about what immunizations to be received by the child
        iv. 7.3.4 • Talk to your baby or child with a soothing voice
    b. • Check if:
        i. 7.3.5 - Vaccines are correct
        ii. 7.3.6 - Checking the expiration date
        iii. 7.3.7 - Dose is correct
        iv. 7.3.8 - injecting the correct place (not in the buttocks for infants aged <1 year)
        v. 7.3.9 - correct syringe (equipment and disposable syringes)
        vi. 7.3.10 • Clean the bottle cap / vial with water cotton DTT
        vii. 3.7.11 • Attract the correct amount of fluid in and out of the vial distinguished
        viii. 7.3.12 • Pull the skin of the anterior thigh (infants) or deltoid muscle (the child) to inject, and insert a needle. (according to the type of vaccination; DPT = intra-muscular, dermal layer BCG, Measles = subcutaneous)
        ix. 3.7.13 • Inject vaccine syringe then pull quickly
        x. 3.7.14 • Disposing of needles and syringes in an appropriate container (do not put the cap back on the needle)
        xi. 3.7.15 • Soothes baby or child and mother or guardians
        xii. 3.7.16 • Wash hands with soap and water then dry or use an alternative hand-washing
        xiii. 3.7.17 • Record the appropriate information on the form and on the immunization card / MCH handbook

4. Immunization orally administered properly
    a. Did midwife
        i. 7.4.1 • Wash hands with soap and water then dry or use an alternative hand-washing
        ii. 7.4.2 • Explain to the mother or caregiver on how to carry a child
        iii. 7.4.3 • Explain to the mother or caregiver about what immunizations to be received by the child
        iv. 7.4.4 • Talk to your baby or child with a soothing voice
        v. 7.4.5 • Check if:
        vi. 7.4.6 - Vaccines are correct
        vii. 7.4.7 - Dose is correct
        viii. 7.4.8 • Provide oral vaccine to infants / children and ensure that children have swallowed it all
        ix. 7.4.9 • Soothes baby or child and the mother or caregiver
        x. 7.4.10 • Wash hands with soap and water and dry
        xi. 7.4.11 • Record the appropriate information on the form and on the immunization card
        xii. 07/04/12 • Memasukakan data into appropriate documentation
5. Management vaccines
    a. Verify:
        i. 7.5.1 • Do vaccines brought in a flask containing ice
        ii. 7.5.2 • After the use, the vaccine is not used is sent back to the health center or stored in the refrigerator (at a temperature of 0-80 C)

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Tool 8: Standard for breastfeeding support

1. Perform Early Initiation of Breastfeeding for babies immediately after birth
    a. 8.1 After the baby is born if a midwife :
        i. 8.1.1 If the baby is breathing normally , drying the baby from head to toe except both hands (palms and backs of hands) thoroughly using a towel to dry without cleaning vernik . Vernik help freshen and warm baby . Back of the hand because the baby is not in the dry smell of amniotic fluid leads attached to the baby find the breast nipple that smells the same
        ii. 8.1.2 Changing the wet towel with a dry and clean towel , wrap the baby including baby's head , (wearing cap) , wait 2 minutes before the umbilical cord is clamped
        iii. 8.1.3 Tengkurapkan baby in the mother's abdomen or chest skin attached to the baby's mother's skin (skin to skin contact) , the position of the baby's head is lower than among the breast

iv. 8.1.4 Allow the baby to crawl and find his own mother's nipple , while the mother was asked to caressing her baby with a soft touch
v. 8.1.5 Allow the baby's skin and skin maternal contact at least 1 hour , even if the baby is menyusuh / find the nipple is less than 1 hour . Let the baby suckle satisfied, remove the mother's own nipple, and even fall asleep with this position.
vi. 8.1.6 If within 1 hour to the unborn find the mother's nipple , hold the baby's mouth to the mother's nipple , and let the mother baby skin contact for 30 minutes or 1 hour later
vii. 8.1.7 If the baby and the mother had to be moved from the delivery room before 1 hour or before a baby suckles , the mother and the baby try to move along with maintaining skin contact and baby
viii. 8.1.8 Attach the mother and baby in the same room , Babies should always be within reach of the capital for 24 hours in a day so that the baby can suckle as they wish

2. Midwives assist mothers to breastfeed
    a. 8.2. Verify whether the midwife :
        i. 8.2.1 Washing hands while drying it before serving mothers and babies.
        ii. 8.2.2 Helping the mother to find a comfortable position for himself before the start of breastfeeding for example
        iii. 8.2.3 Noting while demonstrating the position of the baby for breastfeeding :
            1. The head and the baby's body in a straight line
            2. Baby bodies cuddled close Mother
            3. -The entire body of the baby propped up (especially in newborns)
            4. Infants brought to the breast , nose dealing with nipples
        iv. 8.2.3 Show mothers how to support the breast :
            1. Finger is placed on the chest wall under the breast
            2. At the bottom of the index finger and thumb on the breast above the breast , especially not near the nipple position mengguntung
        v. 8.2.4 Delivering and help the mother to the baby's lips attach nipple :
            1. -Move closer and touched the baby's lips to the mother's nipples
            2. Wait until the baby's mouth is wide open and ready to devour the nipple
            3. Navigate to the baby's lower lip below the nipple
        vi. 8.2.5 Introduce a sign - a sign of good attachment :
            1. When Areola memmae bit , then the entire areola into the mouth , when the mammary areola wide , then more visible areola above the baby's lips from the under
            2. The baby's mouth is wide open

3. The lower lip baby " DOER " (rotated outward)
4. -The chin baby attached to the breast

vii. 8.2.6 Signs Introduce baby to suckle properly :
1. Suction is slow , and there was a pause in the break
2. Cheek rounded baby sucking time
3. Baby releases breast completion time
4. Mother feel relaxed signs of oxytocin (start the flow of breast milk)

viii. 8.2.7 Explaining the mother to breastfeed the baby to the breast itself to remove the whole breast milk the baby gets the start to the end . Once it starts to re-position the baby to the breast next

ix. 8.2.8 After feeding the baby, baby tegakkanlah that rests on the shoulders of the mother and then rub - rub or pat his back gently. It is useful for helping baby burp.

x. 8.2.9 After the baby is finished nursing , explain the signs of the baby 's mother wants to breastfeed :
1. The baby 's tongue licking his lower lip
2. Babies who are not swaddled lick his hand
3. The baby's head moves to the left and right as looking breasts

xi. Babies will probably start crying when the signs above are not followed by finding the nipple. But crying is not only a sign of the baby is hungry so she needs to examine other possibilities such as a wet diaper , or the baby was cold , etc.

3. Counseling to mothers about the benefits of breastfeeding
   a. 8.3. Verify whether the midwife said that :
      i. 8.3.1 · Breast milk is better than the other mammalian milk or any formula for nutrients to baby's needs changing throughout the day.
      ii. 8.3.2 · If breastfeeding has not come out or come out slightly (colostrum), still be given to infants. Reassure the mother that the baby can survive 72 hours without fluid. Mother's shoulder and back massage to relax and help the process of breastfeeding.
      iii. 8.3.3 · Colostrum provides immunity in infants, can protect the baby from gastrointestinal infection.
      iv. 8.3.4 · Breast milk is always available is not practical because it needs to be purchased. Always be given at any time every baby needs .
      v. 8.3.5 · Breastfeeding tightened the relationship between mother and baby and calming for both of them.
      vi. 8.3.6 · Less blood loss and faster uterus return to normal size .
4. Counseling on exclusive breastfeeding

a. 8.4. Verify whether the midwife gave explanations about 6 months of exclusive breastfeeding :
    i. 8.4.1 · exclusively breastfed babies receive only breast milk is only for 6 months , without any other additional fluids such as water , milk, formula , juice, honey , water, tea , and additional solid foods such as bananas , papaya , milk porridge , biscuits , rice porridge and teams .
    ii. 8.4.2 · Suggest breastfed infants be given whenever required (on demand) and midwife explained back the signs of the baby wants to suckle.
    iii. 8.4.3 · For working mothers, midwives help demonstrate how to provide breastmilk to the baby sitter by not using the bottle, or pacifier, but scooped or use a cup. It is important to avoid nipple confusion.

5. Benefits of exclusive breastfeeding
    a. 8.5. Verify whether the midwife gives an explanation of the benefits of exclusive breastfeeding :
        i. 8.5.1 · baby's digestive health
        ii. 8.5.2 · Lowering developmental and behavioral disorders in children
        iii. 8.5.3 · Reducing exposure to risk of vomiting and diarrhea in infants and reduces the chances of constipation
        iv. 8.5.4 Reduce the chances of developing an infection in the chest and ears ,
        v. 8.5.5 Reduce the risk of skin diseases ,
        vi. 8.5.6 Reduce the possibility of the baby having problems of obesity
        vii. 8.5.7 · Breastfeeding children also have a positive effect for the mother , such as reducing the risk of maternal heart disease , reduce the risk of uterine and breast cancer , burn calories in the body of the mother ,
        viii. 8.5.8 · Conserve expenditure , and also foster a strong bond between mother and child
        ix. 8.5.9 · Breastfeeding delays the return of the child is also the menstrual cycle in women who had just given birth.
6. Counseling way breast milk storage
    a. 8.6. Verify whether midwives provide counseling on breastmilk storage method :
        i. 8.6.1 · Breastmilk pumped or stored in a glass / glass bottle (best)
        ii. 8.6.2 · When will give to your baby breast milk within 6 hours after collection , breast milk can be stored at room temperature , and do not need to be stored in the refrigerator ,
        iii. 8.6.3 · If you are going to give breast milk to your baby within 24 hours , ASI can be stored in a flask that was given the ice cubes only.
        iv. 8.6.4 · While breast milk over 72 hours after take ation in breast milk should be stored under refrigeration (below 5 degrees Celsius , not made in a frozen state) ,

v. 8.6.5 · For over 3 months breast milk is stored at the top of the refrigerator (freezer), frozen at temperatures below -18 degrees Celsius . With this special storage can be frozen for 6 months , the rest is not good ation given to infants because if stored for longer than 6 months , the composition of which is contained in breast milk can be decomposed .
vi. 8.6.6 · In addition of the breastmilk storage, the container for the breastmilk should be considered. It's recommended that the breastmilk is stored in container that specifically for the baby equipment. Do not use unstandardized container that will affect the quality of breastmilk for the baby

7. Availability of IEC materials breastfeeding and exclusive breastfeeding
    a. 8.7 Verify whether the midwife has IEC materials for breastfeeding and exclusive breastfeeding :
        i. 8.7.1 Poster breastfeeding position and attachment of the true
        ii. 8.7.2 Benefits of breastfeeding
        iii. 8.7.3 About exclusive breastfeeding

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Tool 9: Standard for infection prevention

1. Polindes / Poskesdes / The Practice; healthy and clean
    a. Check if there is no dust, blood, waste, needles and syringes used and cobwebs in the following places:
        i. 9.1.1 • Place of registration
        ii. 9.1.2 • Space / waiting chair
        iii. 9.1.3 • pat Tem check
        iv. 9.1.4 • The maternity / postpartum
        v. 9.1.5 • Page
        vi. 9.1.6 • Another room
        vii. 9.1.7 • Toilet
2. Equipment and materials available for the Prevention of Infection in the Maternity / Post-Partum
    a. Check if available:
        i. 9.2.1 • Sink with running water or covered bucket with faucet
        ii. 9.2.2 • Liquid soap near the sink / bucket
        iii. 9.2.3 • Lap private hands
        iv. 9.2.4 • Gloves check
        v. 9.2.5 • Gloves DTT / sterile
        vi. 9.2.6 • Dry bins with plastic bags
        vii. 9.2.7 • wet bins with plastic bags
        viii. 9.2.8 • bucket to soak the soiled cloth with detergent
        ix. 9.2.9 • Buckets for water DTT

x. 9.2.10 • Buckets for the chlorine 0.5%
xi. 9.2.11 • Household Gloves
xii. 9.2.12 • Plastic Aprons
xiii. 2.9.13 • Mask
xiv. 9.2.14 • Glass eye
xv. 2.9.15 • Shoes / sandals covered the front
xvi. 9.2.16 • Containers for water DTT in trolley
xvii. 2.9.17 • Containers for 0.5% chlorine solution
xviii. 9.2.18 • Spray bottle filled with 0.5% chlorine and duster
xix. 9.2.19 • The tool DTT / sterile (where parturition sets, hechting sets) with ready-made equipment sterile
xx. 9.2.20 • The leak-proof needle filled to 3/4 full
xxi. 9.2.21 • Korentang
xxii. 9.2.22 • Place (tool storage cabinets)

3. Infection Precautions when done right contact with the patient
    a. Did midwife
        i. 9.3.1 • Wash hands before action
        ii. 9.3.2 • Wash hands after action
        iii. 9.3.3 • Using personal hand wipes
        iv. 9.3.4 • Wear gloves when in contact with body fluids
        v. 9.3.5 • Wear personal protective equipment (if necessary)
        vi. 9.3.6 Signing • the needle and bobbin tube 3 times with a solution of chlorine prior to discharge
        vii. 9.3.7 • Disposing of needles / sharps into a leak-proof needle
        viii. 9.3.8 • Submerge consumable instruments in 0.5% chlorine solution for 10 minutes
        ix. 9.3.9 • Using a spray bottle filled with chlorine for the examining table
4. Clean water available
    a. Were:
        i. 9.4.1 • There is enough water for hygiene purposes workplace, equipment and other materials
5. Containers sharp equipment used correctly
    a. Were:
        i. 9.5.1 • Containers for sharp tool available (cardboard, hard plastic container or tin container with cover) that has a small hole to insert the syringe with the needle
        ii. 9.5.2 * The container must not be the sharpest tool more than 3/4 full
        iii. 9.5.3 * is filled Syringes 0.5% chlorine solution for decontamination before being discharged into the container sharp tool
        iv. 9.5.4 * The container is disposed of correctly

6. Cleaners materials are available and ready to use
    a. Check that:
        i. 9.6.1 • antiseptic ingredients available in small containers and can be reused for everyday use
        ii. 9.6.2 "• Reusable containers are washed with soapy water until it is completely clean, rinsed with clean water and then dried before being recharged "
        iii. 9.6.3 • Reusable containers containing labeled replenishment date
        iv. 9.6.4 • Kassa or cotton stored in a dry container without antiseptic
        v. 9.6.5 • Tools and other materials are stored in a dry container without antiseptic
        vi. 9.6.6 • Korentang stored in containers without antiseptic
        vii. 9.6.7 • Ask if the solution was replaced every day or if it was dirty
7. Chlorine solution for decontamination of equipment and materials are made correctly
    a. Check if:
        i. 9.7.1 • The concentration of chlorine solution is 0.5%:
    b. Liquid chlorine:
        i. 9.7.2 * If using concentrations of 3.5%, 1 part bleach to 6 parts water, or
        ii. 9.7.3 * If using a concentration of 5%, 1 part bleach to 9 parts water, or
        iii. 9.7.4 * If using other concentrations, use the formula below to make a chlorine solution: the total (TB) of water = (% concentrate / 0.5%) - 1 to one part chlorine
    c. Chlorine powder:
        i. 9.7.5 * If using calcium hypochlorite (35%), 14 grams of powder to 1 liter of water, or
        ii. 9.7.6 * If using calcium hypochlorite (70%), 7 grams of powder to 1 liter of water
8. Decontamination equipment and other materials (immediately after use and before washing) done right in the use of tools
    a. Were:
        i. 9.8.1 • new chlorine solution, always prepared early in the day or earlier if it has been gross
        ii. 9.8.2 • The containers are labeled date / time
        iii. 9.8.3 • Plastic containers used for decontamination
        iv. 9.8.4 • Tool and other materials soaked in 0.5% chlorine solution for 10 minutes before taken to wash
        v. 9.8.5 • Tools and materials carried in buckets or leak-proof container leaching into space

vi. 9.8.6 • The syringe and needle that has been used decontaminated in 0.5% chlorine solution before it is inserted into the puncture-resistant containers for sharp instruments

9. There is a place for processing tool with the right groove to avoid cross-contamination
    a. Were:
        i. 9.9.1 • The processing tools are separate from other spaces in polindes
        ii. 9.9.2 • Have good ventilation
        iii. 9.9.3 • Have good lighting
        iv. 9.9.4 • There is a reception desk for materials / equipment dirty
        v. 9.9.5 • At least there is one place in the wash with running water for washing equipment
        vi. 9.9.6 • There is a table for drying equipment
        vii. 9.9.7 • Have a tool boiler or steamer which works fine
        viii. 9.9.8 • Has shelves / cabinets for storage devices that have been clean
        ix. 9.9.9 • Has a shelf with a flip clothesline to dry clean gloves
        x. 9.9.10 • There is a closed cupboard for storing materials / equipment (doors or curtains to cover net tools on the shelf) and access to a storage cupboard or cabinet closed bounded
        xi. 9.9.11 • No liquid spills or water on the floor
        xii. 9.9.12 • Materials / cleaner tool that has been placed on one side of the space and materials / equipment dirty on the opposite side
        xiii. 9.9.13 • Have a channel and adequate sewerage
10. Washing health equipment and other materials done correctly
    a. Did midwife wearing:
        i. 9.10.1 * Household Gloves
        ii. 9.10.2 * Eye protection or face
        iii. 9.10.3 * Aprons plastic
        iv. 9.10.4 * shoes / sandals boots or sandals with closed front
    b. Using:
        i. 9.10.5 * Brush smooth
        ii. 9.10.6 * Detergent (liquid or powder, without acid or ammonia)
        iii. 9.10.7 • Brushing tools and other materials in the water, until all the blood and other impurities truly lost
        iv. 9.10.8 • Removing the appliance parts consisting of several parts and clean the teeth and the connection using the brush
        v. 9.10.9 • Rinsing equipment and other materials thoroughly with clean water
        vi. 9:10:10 • Dry instruments and other materials with a clean cloth or use dianginkan

vii. 9:10:11 • Wash hands with soap and running water for 10-15 seconds then dry or rubbing hands with alcohol-based solution to dry as much 3-5ml

11. The DTT process is done correctly
    a. Did the cycles below followed:
        i. Boil
            1. 9.11.1 • Equipment whose parts have been removed and cleaned, soaked up entirely submerged
            2. 9.11.2 * Closing a boil
            3. 9.11.3 • Equipment / Instrument boiled for 20 minutes counted from the moment the water starts to boil
            4. 9.11.4 • After 20 minutes, the instrument is issued using korentang or gloves has been in DTT / sterile then stored in containers that have been in-DTT
        ii. Using a steamer / steamer (DTT)
            1. 9.11.5 • Fill enough water into the pan to generate steam for 20 minutes
            2. 9.11.6 • Inserting instruments / equipment steamer strainer into taste
            3. 9.11.7 • Keep the steamer remains closed
            4. 9.11.8 • Do not add the contents if the process has already begun
            5. 9.11.9 • Start turning the timer on a sat steam started coming out between sieve steamer
            6. 9:11:10 • Steaming for 20 men it
            7. 9:11:11 • Move each sieve into another pot of boiling dry, shook it to remove excess water available
            8. 9:11:12 • Allowing the instrument / contents, dry in the steamer with closed filter in place over the pot boiling dry
12. There is a system of shelf life for storage of materials / tools DTT Are:
    a. 9.12.1 • Clean Materials stored separately from materials that have DTT
    b. 9.12.2 • Materials / tools used immediately wrapped
    c. 9.12.3 • Package and / or container processing the date written DTT
    d. 9.12.4 • Package / material wrapped not torn, humid, dusty or oily
13. Waste collected properly to avoid injury and contamination
    a. Did midwife
        i. wear:
            1. 9.13.1 * Household Gloves
            2. 9.13.2 * shoes / sandals boots or sandals with closed front
            3. 9.13.3 • Collecting garbage into the container / place leak-proof
            4. 9.13.4 • Collect trash when the bowl is 3/4 full

5. 9.13.5 • Ensure all placental tissue samples or disposed of in a plastic bag two layers
6. 9.13.6 • There is a garbage collection system
7. 9.13.7 - Flow controlled garbage collection (can only be accessed by a midwife)
8. 9.13.8 - Containers must be leak-proof and sealed
9. 9.13.9 - All waste is in the container
10. 9:13:10 - There is no trash on the floor area of garbage collection
11. 9:13:11 • There is a dumpster outside polindes (yard) for general waste that is not scattered
12. 9:13:12 • Yard (outside polindes) is clean
13. 9:13:13 • Keeping the garbage collection area remains clean and no spark
14. 9:13:14 • A garbage collector washing hands with soap water after removing gloves

14. Waste disposed of properly to avoid injury and contamination
    a. Did
        i. Contaminated liquid waste (blood, urine, feces and other body fluids) disposed in the following manner:
            1. 9.14.1 • Dumped into the toilet or sink that has a disposal system
            2. 9.14.2 • The sink is rinsed with water after the waste / liquid manure is discharged
            3. 9.14.3 • Container objects / tools sharp burned, buried, or encapsulated
            4. 9.14.4 • Solid waste (cotton, gauze, and other materials contaminated with blood and organic matter) burned or buried
            5. 9.14.5 • Midwives wear eye protection and gloves household
        ii. If garbage is burned, ask whether:
        iii. 9.14.6 • The flow in this area and should only be accessed supervised by midwives
        iv. 9.14.7 • The area should not be accessed by people and pets
        v. 9.14.8 • Garbage burned in an area that has been determined
        vi. 9.14.9 • Waste sent to the combustion area if you want to be burned
        vii. 9:14:10 • In the event of fire, the fire can be seen up to ashes
        viii. 9:14:11 • The ash from the burning of materials disposed of as waste is contaminated
        ix. 9:14:12 • No garbage strewn on the ground
    b. OR
        i. If the garbage dumped in a hole, ask whether:
        ii. 9:14:13 • penimbungan area should not be accessed by the public, pet

iii. 9:14:14 • Location hoarding is lined with a material with a low absorption rate (e.g., soil hiat)
iv. 9:14:15 • Location accumulation of at least 50 meters from the source / springs, and is located in a flood free area
v. 9:14:16 • Hole accumulation around 1 square meter and a depth of 2 meters
vi. 9:14:17 • Garbage is disposed ditimbuni soil about 10-15 cm every day
vii. 9:14:18 • The final layer thickness of 50-60 cm
viii. 9:14:19 • Hole minimum accumulation for 30-60 days
ix. 9:14:20 • There is no garbage strewn in the yard

c. OR
    i. Encapsulation, ask whether:
        1. 9:14:21 • Objects / sharp instruments are collected in puncture-resistant containers and leak-proof
        2. 9:14:22 • The box has been filled 3/4 full of materials such as cement or clay to actually pen uh
        3. 9:14:23 • The material has hardened
        4. 9:14:24 • The container is sealed
        5. 9:14:25 • The container filled with soil / cement or stockpiled

15. There is a special place for storage washing floors, toilets, windows (Sweep, Mop, Lap, etc.) Are:
    a. 9.15.1 • Equipment stored in a special place and placed in hanging, folded laps stored in a dry state

ANNEX VII. COMMUNITY HEALTH WORKER* TRAINING MATRIX

Project Area (Name of District Or Community)	Type of CHW	Official Government CHW or Grantee-Developed Cadre	Paid or Volunteer	Number Trained Over Life of Project		Focus of Training
				Male	Female	
Cengkareng and Kalideres Districts; and West Jakarta Municipality	Mentor of Mothers Support Group (MSG)	Grantee-developed cadre	Volunteer	1	95	Facilitating training of Motivators, Supervision, Mentorship, and M&E
Jakarta Province	Mentor of Mothers Support Group (MSG)	Grantee-developed cadre	Volunteer	0	36	Facilitating training of Motivators, Supervision, Mentorship, and M&E
Cengkareng and Kalideres Districts	Motivator of MSG	Grantee-developed cadre	Volunteer	0	512	Facilitation of MSG meeting; home visit to mother-newborn; MSG activity documentation Topics: Breastfeeding; hand-washing with soap; balanced nutrition; iron and folic acid supplementation in pregnancy; complementary feeding.
Cengkareng and Kalideres Districts	Facilitator and Course Directors for Breastfeeding Counseling Training	Member of professional organization (IBI)	Paid	0	6 (new)	Breastfeeding Counseling; Kangaroo Mother Care; Mentoring new Counselors
Cengkareng and Kalideres Districts	Breastfeeding Counselors – Public Midwives & Private Midwives	Government Member of professional organization (IBI)	Volunteer	0	120	Breastfeeding Counseling; Kangaroo Mother Care
West Jakarta Municipality	Breastfeeding Counselors - Private Midwives	Member of professional organization (IBI)	Volunteer	0	27	Breastfeeding Counseling Blended Learning Method
Cengkareng and Kalideres Districts	Private Midwives	Member of professional organization (IBI)	Volunteer	0	40	Standard Based Management and Recognition Tools adopted for Private Midwives.
West Jakarta Municipality	Private Midwives	Member of professional organization (IBI)	Volunteer	0	150	Legal Aspects of Breastfeeding Support, Medical Records in practice, Early initiation and Exclusive Breastfeeding
Cengkareng and Kalideres Districts	Private Midwives	Member of professional organization (IBI)	Volunteer	0	62	Asphyxia management and Neonatal Resuscitation, Kangaroo Mother Care and Partograph recording

Cengkareng and Kalideres Districts	*Community (RT and RW) Leaders*	*Government*	*Volunteer*	*26*	*4*	*Basic Knowledge on Maternal Child Health and Nutrition; Bottom-up development planning facilitation; MCH friendly budget proposal*
Cengkareng and Kalideres Districts	*Private Midwives*	*Member of professional organization (IBI)*	*Volunteer*	*0*	*2*	*Basic Knowledge on Maternal Child Health and Nutrition; Bottom-up development planning facilitation; MCH friendly budget proposal*
Cengkareng and Kalideres Districts	*Mentor & Motivator of MSG*	*Grantee-developed cadre*	*Volunteer*	*0*	*15*	*Basic Knowledge on Maternal Child Health and Nutrition; Bottom-up development planning facilitation; MCH friendly budget proposal*
8 sub-districts in Cengkareng and Kalideres Districts	*Community budgeting inception meeting participants*	*Community*	*Volunteer*	*299*	*275*	*Maternal Child Health Nutrition and long-term family investment; MCH friendly budget proposal*
Cengkareng and Kalideres Districts	*Financial Literacy trainer*	*Grantee-developed cadre*	*Volunteer*	*0*	*21*	*Training of Trainers on Financial Literacy trainings – bridging onward discussion on saving from breastfeeding at the community level*
65 RW in Cengkareng and Kalideres Districts	*Financial Literacy trainee*	*Grantee-developed cadre*	*Volunteer*	*70*	*1,998*	*Financial Literacy trainings – bridging onward discussion on saving from breastfeeding at the community level*
Rawa Buaya sub-district	*Trainer m-PWS for Health Workers (Private midwives, Government staff, PKK)*	*Grantee-developed cadre*	*Volunteer*	*0*	*4*	*Facilitating m-PWS training for private midwives; Refresher orientation on MCH services report and technical definition (first Antenatal care, Complete Neonatal care, etc.)*
Rawa Buaya sub-district	*Trainer m-PWS for Community*	*Grantee-developed cadre*	*Volunteer*	*0*	*6*	*Facilitating m-PWS training for community volunteers; on-the job Mentoring; m-PWS e-form troubleshooting*
Rawa Buaya sub-district	Community m-PWS volunteer	*Grantee-developed cadre*	*Volunteer*	*41*	*379*	*Registration of MCH population with m-PWS e-form; Verification of registered population data; Tracking priority MCH target*
Rawa Buaya sub-district	Posyandu m-PWS volunteer	*Member of existing CSO*	*Volunteer*	*0*	*33*	*Registration of MCH population with m-PWS e-form; Verification of registered population data; Tracking priority MCH target*

West Jakarta Municipality	Religious leader; PKK	*Member of existing CSO*	*Volunteer*	*100*	*200*	*City-level Introduction on MCH from the perspective of Islam reference book, booklet and bulletin*
Cengkareng and Kalideres Districts	Religious leader	*Member of existing CSO*	*Volunteer*	*51*	*97*	*Orientation on MCH from the perspective of Islam reference book, booklet and bulletin*
Cengkareng and Kalideres Districts	Mentor of MSG	*Grantee-developed cadre*	*Volunteer*	*0*	*15*	*Orientation on MCH from the perspective of Islam reference book, booklet and bulletin*
Cengkareng and Kalideres Districts	PKK cadre	*Government*	*Volunteer*	*0*	*31*	*Orientation on MCH from the perspective of Islam reference book, booklet and bulletin*
Cengkareng and Kalideres Districts	Public Health Center and Sub-district Government staff	*Government*	*Volunteer*	*6*	*16*	*Orientation on MCH from the perspective of Islam reference book, booklet and bulletin*
Cengkareng and Kalideres Districts	Private Midwives	*Member of professional organization (IBI)*	*Volunteer*	*0*	*6*	*Orientation on MCH from the perspective of Islam reference book, booklet and bulletin*
West Jakarta Municipality	Nutritionist/ Midwives of Public Health Centers	*Government*	*Paid*	*0*	*40*	*Orientation on Infant and Young Child Feeding; and Nutrition Reporting*
Kedaung Kaliangke and Duri Kosambi sub-districts	IYCF Counselor	*Grantee-developed cadre*	*Volunteer*	*0*	*17*	*IYCF counseling*
West Jakarta	Facilitator of IYCF training	*Government*	*Volunteer*	*3*	*17*	*Training of Trainers on Infant and Young Child Counseling*
Jakarta Province	Facilitator of IYCF training	*Government*	*Volunteer*	*1*	*8*	*Trainers on Infant and Young Child Counseling*
Jakarta Province	IYCF Counselor	*Government*	*Volunteer*	*1*	*23*	*IYCF counseling*

ANNEX VIII. EVALUATION SCOPE OF WORK

Terms of Reference for

Final Evaluator External Consultant for the Mercy Corps Hati Kami Project in Jakarta, Indonesia

July 21, 2014

I. Introduction

Mercy Corps will hire an independent consultant to conduct a final performance evaluation (FE) for the Hati Kami project funded by USAID's Child Survival and Health Grants Program (CSHGP) Cooperative Agreement AID-OAA-A-10-00063 which started in September 30, 2010 and will end on September 29, 2014 in Jakarta, Indonesia. USAID's CSHGP supports community-oriented projects implemented by U.S. private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) and their local partners. The purpose of this program is to contribute to sustained improvements in child survival and health outcomes by supporting the innovations of PVOs/NGOs and their in-country partners in reaching vulnerable populations.

This document describes the Final Evaluator's scope of work (SOW) for the Hati Kami FE.

The objectives and intermediate results of the project are:

Objective 1. Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life
IR1. Increased knowledge and skills of mothers on breastfeeding and key maternal-newborn care
IR2. Increased access to social support for mothers on breastfeeding and key maternal-newborn care

Objective 2. Improved quality of maternal, newborn and infant services
IR3. Increased skills and compliance of the health providers on MCHN counseling, AMTSL, essential newborn care, and the baby friendly protocols.
IR4. Increased use of MCH data for decision making and advocacy.

II. Background

Hati Kami, Mercy Corps' four-year (September 30, 2010 to September 29, 2014) Innovation Child Survival and Health project in eight sub-districts of Cengkareng and Kalideres districts in West Jakarta Municipality, Indonesia aims **to promote, support, and protect the mother-child dyad for a healthy start among Jakarta's poor residents.** The project was a response to the high rates of stunting, increased rates of bottle/formula feeding, and limited growth in exclusive breastfeeding (EBF) rates. Working with partners in West Jakarta and the Jakarta Province, the project aims to achieve two Strategic Objectives, benefiting 8,558 pregnant women and 7,723 infants: ***Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life***; and ***Improved quality of maternal, newborn and infant services.*** Key interventions include: establishing Mothers Support Groups (MSGs) for reaching mothers with critical information on breastfeeding and maternal and newborn care; integrating counseling on maternal-infant health and nutrition into the *7 contacts+* in maternal-newborn care; scaling up WHO's 40-hour Breastfeeding Counseling (BFC) training; implementing a contextualized and targeted communication strategy; replicating the Standard Based Management and Recognition (SBMR) approach for private midwives; supporting the

Municipality Health Office (MHO) and local branch of Indonesian Midwives Association (*Ikatan Bidan Indonesia, IBI)* to train providers on kangaroo mother care method; and, replicating the 10 steps to successful breastfeeding model of Healthy Start (Mercy Corp's previous project funded by Child Survival and Health Grants Program, CSHGP). The Operations Research (OR) component is conducted in partnership with the University of Indonesia's Center for Family Welfare Research (CFW-UI). This innovative strategy aims to strengthen the Ministry of Health (MoH) **M**aternal and **C**hild **H**ealth **L**ocal **A**rea **M**onitoring **a**nd **T**racking **(MCH-LAMAT)** system. Mobile phone technology, in conjunction with the LAMAT system (mobile *Pemantauan Wilayah Setempat* or ***'m-PWS'***), is used to monitor and track maternal and newborn health services utilization, and determine if more accurate and timely data from public and private providers will improve service utilization and resource planning.

III. Project Population

West Jakarta Municipality was selected jointly as the project area by Mercy Corps and the Provincial Health Office (PHO) based on the municipality having the poorest health indicators for Jakarta province and where Mercy Corps had established relationships and trust with the local district government and Health Office. Out of 56 sub-districts in West Jakarta, Hati Kami targets poor urban communities in eight sub-districts that are densely populated. Six of those sub-districts belong to Cengkareng district and two belong to Kalideres district.

Beneficiaries*	Total
Total sub-districts	8
Total intervened communities/ neighborhood clusters	94
Total Population	402,240
Total Neonates	643
Infants aged 0–11 Months	7,723
Children aged <5 Years	25,422
Women of Reproductive Age (15–49 years)	131,211
Total Beneficiaries	164,999
Expected Pregnancies	8,111 x 4 years
*Community Health Workers or Volunteers (CHWs), Disaggregated by Sex	236 females only
*Health Facilities (Hospital to Sub Health Post)	547
*Community-Based Structures (e.g., Village Development Committees [VDCs])	113

*Source:Hasil Pemetaan Tenaga Kesehatan dan Sarana Kesehatan Seksi Sumber Daya Kesehatan Suku Dinas Kesehatan Kota Administrasi Jakarta Barat 2010. 18 April 2011

IV. Partners

Hati Kami is implemented in partnership with the Municipal Health Office, specifically, the local public health centers (*Puskesmas)* of the target sub-districts or *kelurahans* or *secondary Puskesmas* of the district level in Cengkareng and Kalideres. Other partners are the local branch of Indonesian Midwives Association (*IkatanBidan Indonesia, IBI)* and the long standing civil society organization named *Pembinaan Kesejahteraan Keluarga (PKK)* [community welfare empowerment organization].

The operations research partner is the University of Indonesia's Center for Family Welfare Research.

V. Key Activities

To date, the project has accomplished the following:

- 94 communities (*rukun warga= RW*) have functioning Mother Support Groups to support pregnant women and mothers of children under 24 months in improving key health behaviors for optimal maternal and child health and nutrition;

- A sermon module which shares key messages for optimal behaviors in pregnancy and lactation and key practices for children < 2 years, has been developed by Muslim leaders and distributed to all local Muslim leaders in Cengkareng and Kalideres districts;

- 8 Kelurahan (sub-districts) have formally budgeted for efforts to support lactating women (mothers of children <2) and pregnant women through annual *Musrenbang* (local government development planning process) in 2012 and 2013;

- 62 private and public midwives participated in refresher courses on asphyxia management and Neonatal Resuscitation, Kangaroo Mother Care (KMC), and use of Partograph;

- As a result of SBMR activities, 40 midwives are complying with the maternal and newborn health service standards;

- One health center catchment area has tested the use of mobile data collection for LAMAT.

VI. Purpose of the Final Evaluation

The purpose of USAID's CSHGP is to contribute to advancing the health system strengthening goals of Ministries of Health toward achieving sustained improvements in child survival and health outcomes, particularly among vulnerable populations, by supporting the innovative, integrated community-oriented programming of PVOs/NGOs and their in-country partners. CSHGP cooperative agreements offer unique opportunities to demonstrate the links between specific delivery strategies and measured outcomes. The FE is intended as a performance evaluation but should be broadly accessible to various audiences including Ministries of Health (MOHs), and findings will contribute evidence relevant to global initiatives such as the Global Health Initiative and Feed the Future.[1] It is important that the final evaluator consider the audiences listed below, when conducting the evaluation and writing the report.

The FE provides an opportunity for all project stakeholders to take stock of accomplishments to date and to listen to the beneficiaries at all levels, including mothers and caregivers, other community members and opinion leaders, health workers, health system administrators, local partners, other organizations, and donors. The FE Report will be used by the following audiences as a source of evidence to help inform decisions about future program designs and policies:

[1]For more information on these two initiatives, visit http://www.usaid.gov and http://www.feedthefuture.gov.

- In-country partners at the local, province, and national levels (e.g., municipality government and its inline offices including health office, city planning and development office, public health centers; IBI and PKK; Province Health Office and the office of province Governor; MOH and other relevant ministries).
- USAID (CSHGP, Global Health Bureau, USAID Missions), and other CSHGP grantees.
- The international global health community. The FE report will be posted for public use at http://www.mchipngo.net and the USAID Development Experience Clearinghouse at https://dec.usaid.gov.

VII. Methodology

The evaluation methodology consists of a mixed-methods approach using both quantitative and qualitative data. The approach comprises both a desk review of secondary data sources and the collection of qualitative data to complement existing data. Mercy Corps will provide the evaluator with a list of possible stakeholder groups, to serve as key informants for interview or survey, who can provide important information to address the evaluation questions. The written design of the evaluation must be further defined and specified by the final evaluator (e.g., number of key informant interviews, focus groups discussions, observations, and locations) and must be shared with project stakeholders and implementing partners for comment before the evaluation commences. Mercy Corps' Director of Public Health will facilitate this sharing and feedback.

Secondary Data:

The final evaluator will review project design and reports (e.g. Detailed Implementation Plan; Annual Reports; Knowledge, Practice, and Coverage baseline; and any other monitoring reports) to assess the quality of quantitative and qualitative data and make assessments of project results in relation to the project design and targets set. The final evaluator should also review key U.S. Government/USAID strategic documents at the global and national levels relevant to the content of project. All relevant policy and strategy documents at the province and national levels (e.g., *Instruksi/ Keputusan/ Peraturan Gubernur*, *Peraturan Menteri Kesehatan*, *Peraturan Pemerintah*, *Rencana Aksi Nasional, etc.)* as well as national demographic and/or health studies/surveys (e.g. Indonesia Demographic and Health Survey 2012; *Riset Kesehatan Dasar 2013;* etc.*)* are also crucial and should be used and referenced.

Qualitative Data:

In-depth qualitative interviews, focus group discussions, and/or workshop will be conducted with stakeholders, including project staff, government health staff, private midwives, local NGOs and community-based organizations, district health teams, community health workers (*kaders*), MSG facilitators, community members, community leaders, and mothers. If possible, the assessment will also include observations of activities supported by the project. This will involve site visits to the implementation areas. It will be up to the final evaluator whether randomly selected communities will be visited from a list provided by Mercy Corps Indonesia or purposive sampling will be used in order to explore certain areas in more depth to investigate particular results (e.g., high or low performance or unexpected results); the final KPC survey may help provide some criteria for site selection.

Quantitative Data:

Mercy Corps Indonesia will collect quantitative data in June and July, 2014, to measure the indicators approved in the DIP and the Rapid Catch indicators. They will use the same questions used for the baseline and the same sampling methodology (30 cluster) to assure the results are comparable to the baseline. The data will be analyzed during the month of July and the final evaluation consultant will receive the analysis by August 1. She will then guide the MC Indonesia staff to conduct any further analysis and prepare tables needed for the final evaluation report. She will write up the final KPC report as one of her deliverables.

Limitations:

The evaluation report must include a discussion of the methodological limitations of the evaluation.

Additional guidance on reporting format is provided in the CSHGP Guidelines for Final Evaluations, specifically in the Final Evaluation Report Template included therein.

VIII. Evaluation Questions

The final evaluator and the evaluation team will use existing data collected or compiled during the life of the project, as well as additional data collected during the evaluation to answer the following questions:

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the DIP?

- To what extent and in what ways does the participation in Mothers Support Group increase the knowledge and skills of pregnant and lactating women on breastfeeding and nutrition practices (IR1)?
- To what extent and in what ways did the Hati Kami activities build local capacity for the planning and management of an expanded MSG program? In what ways did increased capacity contribute to increased access to social support for mothers on breast feeding and key maternal-newborn care (IR2)?
- To what extent and in what ways did the Hati Kami activities increase skills and compliance of the health providers, particularly midwives (both private midwives and *Puskesmas'* midwives) (IR3).
- To what extent and in what ways did the use of mobile technology increase the use of MCH data for decision making and advocacy (IR4).

2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

- What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, and/or health services characteristics,[2]and so forth that affected implementation and outcomes?
- What other activities (conducted by either Mercy Corps and/or by other parties i.e. *Puskesmas, Posyandu*, Religious Leaders, other NGO) may have influenced the pregnant and lactating women's decision to breastfeed exclusively?
- What other activities (conducted by either Mercy Corps and/or by other parties (i.e. *Puskesmas, Posyandu*, Religious Leaders, other NGO, etc.) may have influenced the pregnant and lactating women's decision to eat more staple food and/or more diverse food?

3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?

- Have linkages been developed between parties/ actors necessary for continued support for MSG roll out independently of Mercy Corps Indonesia's assistance? What is there? What is missing?
- Analyze the elements of scaling-up and types of scaling-up that have occurred or could likely occur (dissemination and advocacy, organizational process, costs and/resource mobilization, monitoring and evaluation using the ExpandNet resource for reference).[3]
- Which model, strategies and/or approach will the Municipal Health Office continue to implement beyond Hati Kami? Why? Or why not?
- Did Hati Kami approaches/ activities have any influence to the Puskesmas's resource commitment to maternal child health and nutrition? How?

4. What are stakeholder (community members, Municipality Health Office) perspectives on the OR implementation, and how did the OR study affect capacity, practices, and policy?

IX. Final Evaluator Characteristics and Expected Timeline

The consultant will serve as the evaluation team leader and is welcome to propose additional evaluation team members to round out the evaluation team's skill set in order to ensure adequate representation of evaluation, technical, geographic, cultural and language skills. Team members, their affiliations, and disclosure of conflicts of interest must be listed in an annex to the evaluation report. The consultant will coordinate closely with the Mercy Corps team regarding tool finalization, evaluation methodology, timeline, and draft report finalization.

Requirements:

The consultant must be approved by USAID CSHGP and should meet the following minimum requirements:

[3] http://expandnet.net/PDFs/ExpandNet-WHO%20Nine%20Step%20Guide%20published.pdf

[3] http://expandnet.net/PDFs/ExpandNet-WHO%20Nine%20Step%20Guide%20published.pdf

- Proven expertise and leadership in
  - integrated community-oriented reproductive, maternal, newborn, and child health projects
  - conduct of evaluations (baseline, endline) using mixed methods
- Experience with design, collection, and analysis using applied research methods in a program implementation context
- Familiarity with public health system in Indonesia.
- Demonstrated ability to communicate with and lead a team of stakeholders, staff, and national experts in participatory evaluation
- Familiarity with USAID programming
- Skill or familiarity with cost analysis methods for program assessments
- Excellent analytical and writing skills (English)
- Signed statement explaining any conflict of interest[4]

Key Tasks of the Evaluation Team Leader:

- Review project documents and resources to understand the project
- Refine the evaluation objectives and key questions based on the CSHGP guidelines in coordination with Mercy Corps team and its partners
- Assist the Mercy Corps country office staff to prepare KPC results and to write the final KPC report for inclusion with the final evaluation report to USAID.
- Develop the field evaluation schedule and assessment tools
- Train enumerators and team members on objective and process of the evaluation including evaluation tools
- Lead the team to complete the collection, analysis, and synthesis of qualitative information regarding the program performance
- Interpret both quantitative and qualitative results and draw conclusions, lessons learned, and recommendations regarding project outcome
- Lead an in-country debriefing meeting with key stakeholders, with a PowerPoint slideshow deliverable, no longer than 20 slides (with USAID/Washington, DC, participation remotely, as able)
- Prepare draft report in line with the CSHGP guidelines and submit to EnCompass and Mercy Corps simultaneously on or before October 6, 2014.
- Prepare and submit the final report, which is due at the USAID CSHGP GH/HIDN/NUT office on or before 90 days after the end of the project

[4]CSHGP grantees are required to hire an external evaluator for the final evaluation. That fiduciary relationship creates a conflict of interest that is minimized by the CSHGP requirement of submission of a draft evaluation report directly to the CSHGP.

Timeline:

Task	Date	Time	Location
KPC review, discussion, report-writing	August 31, September 1-5	3 days	home
Review of OR report	August 20	1 day	home
Qualitative evaluation process, findings workshop, presentation	September 8-22	15 days	Jakarta
Draft Report writing	September 25-29	5 days	home
Final Report writing	October 1-10	5 days	Home
Total		29 days	

X. Final Evaluation Report

The FE report should follow the outline in USAID CSHGP's Guidelines for Final Evaluations, informed from input from EnCompass. A draft report will be submitted to EnCompass and the final report, written by the final evaluator, will be submitted directly to the CSHGP. Draft and final reports should be submitted according to the submission instructions as indicated in the guidelines.

XI. Budget

The allocated level of effort is a total of 24 days. The level of budget allocated is as follows:

- Daily rate of $__ x 29 days: $__
- Travel, accommodation and per-diem: return trip Idaho – Jakarta: $5,180
    - Airfare : $2500
    - Visa on arrival : $25
    - Perdiem (Meals & Incidental): $56 x 15 days: $840
    - Maximum Hotel Rate : $121 x 15 days: $1,815
- Production and shipping of Final Report to USAID: $100

XII. Deliverables

At the conclusion of the consultancy period, the consultant is expected to complete the following deliverables:

- Prepare the report for the final KPC survey using analysis and data provided by Mercy Corps

- Lead an in-country debriefing meeting with key stakeholders (and possible remote participation by USAID/Washington, DC) with a PowerPoint presentation no longer than 20 slides for distribution
- Prepare a draft report in line with the CSHGP guidelines and submit to EnCompass and Mercy Corps simultaneously on or before October 6, 2014.
- Prepare and submit the final report, which is due to USAID CSHGP GH/HIDN/NUT office on or before 90 days after the end of the project

ANNEX IX. EVALUATION METHODS AND LIMITATIONS

The lead evaluator, an external consultant hired by Mercy Corps and approved by USAID, arrived in country September 11, 2014 and spent two weeks there for the Final Evaluation. The team was composed of an external consultant who served as lead evaluator; members of the Hati Kami project team; and four external partners representing the West Jakarta branch of IBI (Indonesian Midwives Association), the Municipality Health Office (MHO), the Kalideres Health District, and the Cengkareng Health District, the two districts where project implementation took place. All four external partners were health professionals and had been involved in various aspects of Hati Kami. In addition to the core team, a second external consultant was hired part-time to conduct some of the KIIs with private midwives and PHC staff.

The evaluation team was responsible for collecting and analyzing qualitative primary data using focus group discussions (FGDs), KIIs and observation. The team also reviewed and analyzed secondary quantitative data from baseline and endline surveys and assessments. In addition to the qualitative and quantitative data, the lead evaluator also completed a thorough document review including the original proposal narrative, the DIP, annual reports, reports to donors, strategies such as the BCC strategy, midterm assessments, and reports sent by external visitors. She also used observation as a technique, especially of interactions among the Hati Kami team, partners and beneficiaries.

Qualitative Data Collection

Prior to her arrival in country, the lead evaluator worked with the Hati Kami team to identify potential individuals and groups to interview. Because Hati Kami works through existing structures and organizations and because it has substantial community involvement, the initial list of people to interview was too ambitious for the two-week time period. In consultation with the Health and Nutrition Program Manager and the M&E Specialist, the lead evaluator made the decision to include the following individuals and groups in the qualitative data collection:

- For FGDs: MSG participants; MSG Motivators; community leaders and CHWs involved in m-PWS
- For KIIs: Private midwives; MSG Mentors (primarily PKK members); PHC staff; all Hati Kami staff; MHO; IBI; PKK; the Mercy Corps/Indonesia Country Director; the Mercy Corps/Indonesia Finance Director; the Director of Public Health at Mercy Corps headquarters; and a consultant who had provided substantial technical assistance

Draft data collection instruments were developed by the lead evaluator prior to her arrival in country and then revised and translated during a one-day workshop with the Hati Kami team. Each instrument included a set of generic questions to allow for cross-comparison of responses from different groups and individuals. The majority of these generic questions focused on the four Learning Themes: Community Engagement; Service Delivery and CQI; Scale up and Sustainability; and Learning and Adaption. The revised instruments were then shared with the entire evaluation team during a one-day workshop and members of the team had the opportunity to practice using them via role plays. Given time constraints and the number of instruments, it was not possible to conduct a field test but following the first day of field work, the team met to discuss how well the instruments worked and modified both FGD guides to eliminate repetitious questions and questions that yielded little useful information.

The FGDs were conducted by two people, usually a Hati Kami team member paired with one of

the external partners. In some cases, however, the interview team was composed of two Hati Kami team members as there were only four external partners available. The lead evaluator conducted all the KIIs with Mercy Corps personnel, including the project staff; she also conducted approximately half of the other KIIs. A part-time consultant conducted some of the KIIs with private midwives and PHC staff. The lead evaluator and the part-time external consultant also observed several of the FGDs with Motivators and MSG participants.

In **selecting sites and participants** for the qualitative data collection, an important criterion was to ensure that all eight sub-districts were represented. To this end, one FGD with Motivators and one FGD with MSG participants were conducted in each sub-district for a total of 16 FGDs for these two groups. Since these FGDs needed to be scheduled prior to the lead evaluator's arrival in country, the Hati Kami team relied on Mentors, Motivators and PHC staff to ensure that each FGD had 10-12 members.

In choosing the six PHCs for KIIs, it was important to include the two PHCs involved in the OR: Rawa Buaya, the intervention site, and KKA, the control site. For the remaining four, the Hati Kami team prepared a list of potential PHCs and the lead evaluator randomly selected two from each district. The same system was used to select the private midwives, with the lead evaluator randomly selecting four from a list. As for the Mentors, priority was given to Mentors who were PKK members since this civil society organization plays an important role in the project.

To facilitate the **analysis of the qualitative data**, team members took time at the end of each day of field work to record responses in spreadsheets. At the end of the field work the evaluation team met in a one-day workshop to analyze results, draw preliminary conclusions and propose recommendations. Following the workshop, the lead evaluator organized a series of shorter meetings with the Hati Kami team for additional analysis. The lead evaluator triangulated findings from the document review, her observations of interpersonal dynamics and the quantitative data from the endline surveys and assessments. Additional input was provided by the stakeholders when the preliminary results were shared.

Possible limitations of the qualitative evaluation methodology include the following:

1. *Having Hati Kami team members on the evaluation team*: This could introduce bias into the data collection. To mitigate this possibility, Hati Kami team members did not conduct interviews in their supervision areas and when possible, they were paired with an external partner. To further mitigate bias, all but three of the KIIs were conducted by the external consultants. The KIIs conducted by project staff were three of the four interviews with Mentors.

2. *Time constraints*: Conducting the entire qualitative evaluation, including preparatory workshops and dissemination meetings, in two weeks was challenging. One result was that not all groups could be interviewed. If more time had been available, it would have been useful to interview religious leaders, other members of the organizational partners, more government officials, and additional community leaders. The time constraint also negated the possibility of using recorders and transcribing the interviews later.

3. *Translators*: Both external consultants relied on translators for a number of their interviews. Although the translators were competent, it is likely that some key information was missed.

4. *Choice of sites and participants*: Although a certain amount of randomness was introduced into the selection of sites and participants, the initial lists were prepared by project staff. This

was both a factor of time available and the need to set up the FGDs and KIIs in advance.

Quantitative Data Collection
Especially useful for triangulation was the data from the endline quantitative surveys and assessments conducted from June through August 2014. These included two population-based surveys to measure the impact of Objective 1: a repeat of the baseline KPC Survey with mothers of CU2 and a repeat of the baseline Maternal Nutrition survey with pregnant women. The cluster sampling method was applied for both surveys, with clusters defined as the community neighborhood unit (RW). The endline instruments omitted some questions used in the baseline that were no longer applicable (e.g., planned activities that were not implemented such as the use of SMS for BCC).

For Objective 2, the evaluation team used the results of two endline assessments, which repeated the baseline assessments: an assessment of SBMR with 25 private midwives and an assessment of baby-friendly protocols at 20 health facilities in the project area.

Data Quality and Use
In terms of data available to the evaluation team, the evaluation team did not use data from the MoH or other government agencies as it is not always reliable. Even obtaining realistic population figures for the two districts was problematic. As for the qualitative data collection, it has already been noted that the team was not able to interview all groups involved in the project due to time constraints. Even for the groups selected, it would have been helpful to have more interviews, especially with private midwives and the key organizational partners, including the administrative authorities and religious leaders.

The quality of the quantitative data was good and the M&E Specialist promptly provided explanations and additional data upon request. However, three of the Key Program Indicators needed to be recalculated during the final evaluation. For the EBF indicator, a child who was exclusively breastfed in the past 24 hours but who had had a prelacteal feed was not counted as exclusively breastfed. The baseline and endline values were recalculated using the Rapid CATCH definition. The other two Indicators that were revised were the Counseling Access for Mothers and the Counseling Access during Pregnancy Indicators. Both indicators state "…received counseling on breastfeeding or maternal and infant care messages". However, in the baseline respondents had to answer all messages in order to be counted. In recalculating the values, respondents who answered either breastfeeding or maternal and infant care messages (or both) were counted.

Attribution: Two factors facilitated attribution of results to the project: the project design and the project documentation. The clarity of the project design, the logic connecting the two Objectives and the four IRs and the fact that the design, including the number of activities, was not too ambitious made it easier to determine to what extent the project activities and strategies contributed to the results. Good documentation, especially for Years 1-3, provided not only descriptions of what activities were implemented but also the constraints encountered and how the project team overcame problems and setbacks. A third factor that facilitated attribution is the fact that no other organizations are carrying out similar activities in the project area.

Additional Information: Two attachments provide additional information on the methodology:

1. *Distribution of SOW Key Questions and CSHGP Final Evaluation Learning Themes*: This shows how the Questions and Learning Themes are distributed across the FGD and KII instruments.
2. *Qualitative Evaluation Field Work Schedule*

DISTRIBUTION OF SOW KEY QUESTIONS AND CSHGP FINAL EVALUATION LEARNING THEMES

KEY QUESTIONS FROM SCOPE OF WORK				
	To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the Detailed Implementation Plan (DIP)?	***What were the key strategies and factors, including management issues, that contributed to what worked or did not work?***	***Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?***	***What are stakeholder (community members, Municipality Health Office) perspectives on the Operations Research (OR) implementation, and how did the OR study affect capacity, practices, and policy?***
MSG Participants (FGD)	✓	✓	✓	
MSG Motivators (FGD)	✓	✓	✓	
Community leaders and CHWs involved in m-PWS			✓	✓
MSG Mentors (KII)	✓		✓	
Private midwives	✓	✓	✓	✓ (for the 2 midwives in Rawa Buaya sub-district)
PHC staff	✓	✓	✓	✓
Municipality Health Office	✓	✓	✓	✓
IBI	✓	✓	✓	
Hati Kami project staff	✓	✓	✓	✓
Mercy Corps Indonesia Country Director	✓	✓	✓	

Mercy Corps Indonesia Finance Director		✓		
Director of Public Health/Mercy Corps HQ	✓	✓	✓	
Consultant who provided technical assistance	✓	✓		
PARTICIPANTS	**CSHGP FINAL EVALUATION LEARNING THEMES**			
	Community Engagement	***Service Delivery and Continuous Quality Improvement***	***Scale up and Sustainability***	***Learning and Adaptation***
MSG Participants (FGD)	✓		✓	
MSG Motivators (FGD)	✓		✓	
Community leaders and CHWs involved in m-PWS	✓		✓	✓
MSG Mentors (KII)	✓	✓	✓	
Private midwives	✓	✓	✓	✓ (for the 2 midwives in Rawa Buaya sub-district)
PHC staff	✓	✓	✓	✓
Municipality Health Office	✓	✓	✓	✓
IBI	✓	✓	✓	
Hati Kami project staff	✓	✓	✓	✓
Mercy Corps Indonesia Country Director			✓	
Mercy Corps Indonesia Finance Director				
Director of Public		✓	✓	✓

Health/Mercy Corps HQ				
Consultant who provided technical assistance		✓	✓	

Qualitative Evaluation Field Work Schedule

	10 September 2014	11 September 2014	12 September 2014	13 September 2014	16 September 2014
MSG Motivators	**District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Ellen and Friana **#:** 11 women **District:** Cengkareng **Sub-district:** Cengkareng Barat **Team:** Asep and Didit **#:** 10 women **District:** Kalideres **Sub-district:** Tegal Alur **Team:** Gun and Roro **#:** 7 women	**District:** Cengkareng **Sub-district:** Cengkareng Timur **Team:** Ellen and Friana **#:** 11 women **District:** Cengkareng **Sub-district:** Duri Kosambi **Team:** Ika and Nova **#:** 13 women	**District:** Cengkareng **Sub-district:** Kedaung Kali Angke **Team:** Asep and Nova **#:** 7 women **District:** Cengkareng **Sub-district:** Kapuk **Team:** Ellen, Friana, Sari **#:** 8 women **District:** Kalideres **Sub-district**: Kamal **Team:** Erna and Ika **#:** 6 women		
MSG Participants	**District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Ika and Erna **#:** 11 women **District:** Cengkareng **Sub-district:** Cengkareng Barat **Team:** Fajar and Evi **#:** 2 women **District:** Kalideres **Sub-district:** Tegal Alur	**District:** Cengkareng **Sub-district:** Cengkareng Timur **Team:** Asep and Evi **#:** 2 women **District:** Cengkareng **Sub-district:** Duri Kosambi **Team:** Jabbar and Roro **#:** 7 women (1 came late)	**District:** Cengkareng **Sub-district:** Kedaung Kali Angke **Team:** Roro and Gun **#:** 5 women **District:** Cengkareng **Sub-district:** Kapuk **Team:** Fajar and Evi **#:** 6 women **District:** Kalideres **Sub-district:** Kamal		

	Team: Jabbar and Nova **#:** 4 women		**Team:** Didit and Jabbar **#:** 7 women		
PHC Staff	**District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Kathy **#:** 1 woman **District:** Kalideres **Sub-district:** Kamal **Team:** Shaula **#:** 2 women	**District:** Cengkareng **Sub-district:** Kapuk **Team:** Shaula **#:** 2 women	**District:** Cengkareng **Sub-district:** Kedaung Kali Angke **Team:** Kathy **#:** 1 man 3 women **District:** Cengkareng **Sub-district:** Duri Kosambi **Team:** Shaula **#:** 2 women		**District:** Kalideres **Sub-district:** Pegadungan **Team:** Shaula **#:** 1 woman
Private Midwives	**District:** Kalideres **Sub-district:** Kamal **Team:** Shaula **#:** 1 woman	**District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Kathy **#:** 1 woman **District:** Cengkareng **Sub-district:** Duri Kosambi **Team:** Shaula **#:** 1 woman	**District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Kathy **#:** 1 woman		
Mentors for MSG Motivators				**District:** Cengkareng **Sub-district:** Cengkareng Timur **Team:** Kathy **#:** 1 woman **District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Fajar and Jabbar **#:** 1 woman **District:** Cengkareng **Sub-district:** Cengkareng Barat **Team:** Tani and Gun	

				#: 1 woman **District:** Cengkareng **Sub-district:** Kedaung Kali Angke **Team:** Didit and Ali **#:** 1 woman	
m-PWS Volunteers and Community Leaders		**District:** Cengkareng **Sub-district:** Rawa Buaya **Team:** Kathy **#:** 1 man 10 women			
IBI Leaders					**District:** Kalideres **Sub-district:** Pegadungan **Team:** Kathy **#:** 1 woman

Total participants: 149 (Does not include 15 additional KIIs conducted by the lead evaluator with Hati Kami staff, Mercy Corps Indonesia staff, Mercy Corps HQ and a consultant)

ANNEX X. QUALITATIVE DATA COLLECTION INSTRUMENTS

HATI KAMI ENDLINE QUALITATIVE EVALUATION

GUIDE FOR

COMMUNITY LEADERS AND VOLUNTEERS: m-PWS

(Participants are community leaders and volunteers who have been assisting with m-PWS.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out more about your role in the m-PWS. We would also like to know what you think about the Hati Kami project (the Mercy Corps health project) in general. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	11 September 2014
Name of Interviewer	
Name of Reporter	
Kecamatan *District*	
Kelurahan *Sub-District*	
Number, types of participants	Community leaders:_____ Men _____ Women Volunteers: _____ Men _____ Women
Interview Time	Started: Ended:

General Information

1. Before we begin to talk about m-PWS, I would like to know a little more about whether you do other activities with the project.

    a. Community leaders:
    b. Volunteers:

2. What is your understanding of the purpose of the Hati Kami project/ Mercy Corps work?

Collaboration (m-PWS)

3. How do you help with the m-PWS? (What do they do?)

    a. Community leaders:
    b. Volunteers:

4. What is your opinion of the m-PWS (model)?
   (***Probe: What do you like about m-PWS? What don't you like about it?***)
5. What are some of the problems/challenges you have had in using m-PWS?
6. Could m-PWS be improved to be more helpful to you/easier to use? How?
7. When the project ends: Do you think you will be able to continue using m-PWS?

    If YES:
    a. Will you need any support to be able to continue using this technology?

    b. What support?

    If NO:
    c. Why not?

8. Do you think m-PWS is something that can be scaled up for other community leaders and volunteers to use?

    If YES:

a. What steps would need to take place to scale it up?

If NO:

b. Why not? What would make it difficult to scale it up for other community leaders and volunteers?

Service Delivery/ Quality

9. Has Hati Kami helped improve the quality of maternal and child health **services** in your community?

____ Yes
____ No

If YES:

a. What improvements do you notice in the services?
b. How has the project done this? What specific activities have they supported?
c. Do you think these improvements will continue after the project ends?

____ Yes
____ No

(1) Why do you think this?

If NO:

d. What could the project have done differently to improve the quality of maternal and child health services?

10. Have these improvements in services led to better health for women and young children?

a. **If YES:** What do you observe? How do you know the project has led to better health?

Thank you very much for agreeing to spend time with us and for your comments. We appreciate it.

*Signature of interviewer:*_____*Date:*_____

*Signature of reporter:*_____*Date:*_____

*Reviewed by:*_____*Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

FOCUS GROUP DISCUSSION GUIDE FOR

MSG MOTIVATORS

(Participants are MSG Motivators who are active. The ideal number in the group is 10-12.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out what you know about the Hati Kami project and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

IDENTIFICATION	
Date	September 2014
Name of Interviewer	
Name of Reporter	
Kecamatan *District*	
Kelurahan *Sub-District*	
How many MSG do you represent?	
Interview Time	Started: Ended:
Number of participants	

General Information

1. How long have you been Motivators for the MSG?

   …… Say less than 1 year
   …… Say 1-2 years
   …… Say more than 2 years

2. How were you selected?
   ….. Says appointed (***Ask by whom***:
   ….. Says volunteered (***Ask: Why did you volunteer?)***
   ….. Other method (***Specify:***

3. Who usually **participates** in the MSG meetings? (***Circle the ones who participate; exclude mentors, midwives***)
   a. Some pregnant women
   b. Some mothers of children under 2
   c. Other women (***Specify:***

4. How were these women informed about the MSG/how were they invited to be members? Please explain the process.

5. Since you started participating in the MSG, have the members changed? (Have some members left and new members joined?)

   …. Say Yes
   …. Say No.

6. Please describe a typical meeting. What do you do? How do you conduct the meeting?

7. Do you have lesson plans/modules? Visual aids/teaching aids?

   ____ Say Yes
   ____ Say No

   a. Do you use the ones provided by Mercy Corps?

____ Say Yes
____ Say No

b. Have you created your own tools/aids? Please give examples.

BCC

8. What are the key messages you promote? What are the main practices and behaviors you encourage?

a. Breastfeeding:

-
-
-

b. Women's nutrition when they are pregnant/when they are breastfeeding:

-
-
-
-

c. Infant and child nutrition:

-
-
-
-

d. Other topics:

-
-
-
-

9. Do the women hear the same messages on breastfeeding from other channels/other sources?

a. **If YES**: What are the channels? [**Do not read the answers below**.]

__ Other activity

(Ask for name of activity) _____
__Health care providers at Puskesmas
__Private health care providers
__Radio
__TV
__Posters
__ Other (Specify: _____)

10. Do the women hear the same messages on <u>maternal nutrition</u> from other channels/other sources?

    a. **<u>If YES</u>**: What are the channels? [**Do <u>not</u> read the answers below**.]

    __ Other activity
    (Ask for name of activity) _____
    __Health care providers at Puskesmas
    __Private health care providers
    __Radio
    __TV
    __Posters
    __ Other (Specify: _____)

11. Of these practices/behaviors: Which are the easiest for the women to adopt? (What changes are easiest?)

12. Which practices/behaviors are the most difficult for women to change/adopt?

<u>Job Satisfaction and Challenges</u>

13. What are the highs in your work as an MSG Motivator?

14. What are the lows in your work as an MSG Motivator?

15. Can you give me some examples of how you believe you were able to help a woman with a particular problem? (2-3 quotes/ examples)

<u>Sustainability</u>

16. Do you think you will be able to continue your work as a Motivator after Hati

Kami ends?

a. **If YES**: Why do you think you will be able to continue?

b. **If NO**: Why not?

17. If any party wants to start a similar program with MSG, what should they do differently to improve the MSG approach? What changes would you propose for such a program?

Thank you very much for agreeing to spend time with us and for your comments. We appreciate it.

*Signature of interviewer:*_____ *Date:*_____

*Signature of reporter:*_____ *Date:*_____

*Reviewed by:*_____ *Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

FOCUS GROUP DISCUSSION GUIDE FOR

MSG Participants

(Participants are pregnant women and women with children under 2 who participate in an MSG. No MSG Motivators should be present. The ideal number is 10-12 women.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out what you know about the Hati Kami project and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	_____ September 2014
Name of Interviewer	
Name of Reporter	
Kecamatan *District*	
Kelurahan *Sub-District*	
Number of MSG involved	
Interview Time	Started: Ended:
Number of participants	Women: Men:

General Information

1. Since when have you been members of an MSG? (how many years have you been participating):
   - ____ Say less than 1 year
   - ____ Say 1-2 years
   - ____ Say more than 2 years

2. How did you learn about the MSG? (Who invited you to participate?)

   a. …… from Motivators
   b. ……. from Kader
   c. ……. from Midwife
   d. ……. from other health staff of *Puskesmas*
   e. ……. from others (specify)……

3. Why do you come to the MSG?
4. On average, how many women come to each MSG meeting?
   a. ……. Say less than 5
   b. ……. Say 5-10
   c. ……. Say more than 10

5. Who usually **participates** in the MSG meetings? (circle the ones who participate; exclude mentors, midwives if mentioned)

   a. Some pregnant women
   b. Some mothers of children under 2
   c. Other women (specify)_____

6. Since you started participating in the MSG, have the members changed? (Have some members left and new members joined?)
   a. ……. Say Yes
   b. ……. Say No.

7. Please describe a typical meeting. What do you do? How does the Motivator conduct the meeting?

   Kalau sedang pertemuan KP Ibu, Ngapain aja sih bu? Motivatornya ngapain?

8. Do the women in your MSG share ideas with each other about things they have tried? (***Probe: Try to find out if there are exchanges among the women or if it is the Motivator giving a talk***.)

BCC

9. What are the key messages you have learned from MSG about:

   a. Breastfeeding:
      -
      -
      -

   b. Your own nutrition when you are pregnant/when you are breastfeeding:
      -
      -
      -
      -

   c. Infant and child nutrition:
      -
      -
      -
      -

   d. Other topics:
      -
      -
      -
      -

10. Out of the messages you mentioned just now, can you share 2-3 examples/stories of what you have tried? Did it work or not?
11. Do you hear the same messages on breastfeeding from other channels/other sources?

   a. **If YES**: What are the channels? [**Do not read the answers below**.]

__Other activity
(Ask for name of activity) _____
__Health care providers at Puskesmas
__Private health care providers
__Radio
__TV

__Posters
__ Other (**Specify**: _____)

12. Do you hear the same messages on <u>maternal nutrition</u> from other channels/other sources?

    a. **<u>If YES</u>**: What are the channels? [**Do <u>not</u> read the answers below**.]

__Other activity
(Ask for name of activity.) _____
__Health care providers at Puskesmas
__Private health care providers
__Radio
__TV
__Posters
__ Other (**Specify**: _____)

13. What do you like best about the MSG?
14. What do you like least about the MSG?
15. What is different for you as a mother before and after you joined MSG? Please give some examples. (***Probe: We would also like to know whether the MSG has improved social cohesion.)***
16. Do you share what you learn at the MSG with anyone else?

<u>If YES</u>:
a. With whom? …….
b. What messages have you shared?
c. Did you observe any results after you shared these messages? Please describe.

<u>Sustainability</u>

17. If other people want to organize MSG, what should they do differently? What changes would you propose for such a program?

Probe:
- Meeting frequency:
- Method: (one way talk by motivator, sharing, etc.)
- Meeting place:

Thank you very much for agreeing to spend time with us and for your comments.

*Signature of interviewer:*_____*Date:*_____

Signature of reporter: _____ *Date:* _____

Reviewed by: _____ *Date:* _____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

INDIVIDUAL INTERVIEW GUIDE FOR

HATI KAMI STAFF

(Participants are Hati Kami staff.)

INFORMED CONSENT

As you know, I will be interviewing as many of the Hati Kami staff as possible. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	September 2014
Name of Interviewer	
Name of Reporter	
Interview Time	Started: Ended:
Position of participant	Women: Men:

General Information

1. Can you tell me a little bit about your background:

    a. Your education/training:
    b. How long you have been with the project:
    c. If you worked with other projects before coming to Hati Kami:

2. Can you tell me a little about your responsibilities in the project?

3. What have been the key achievements (visible results) of the project to date?
4. What are you most proud of personally – a personal "triumph"?
5. How is this project different from other projects that you know (especially other NGO projects)?

Community Engagement

6. What activities have been the most important for improving the community's involvement?
7. BCC: Has the project made a special effort to reach men/adolescents/older women who can influence younger women?
8. Do you think the Puskesmas are doing things differently in MCH health and nutrition as a result of their collaboration with the project? (***Probe: Quality of care? More outreach? Better BCC methods? Etc.***)

    If YES:
    a. What are they doing differently?

        (1) Will these changes continue after Hati Kami ends?

Service Delivery/Quality

9. Has the project helped improve the skills and compliance of health care providers (Puskesmas, private)?

    a. **If YES**:
        a. How do you know this?
        b. Which health care providers has the project helped the most? (***Probe for private midwives too.)***

10. Has the project helped improve the quality of maternal and child health services?

    If YES:
    e. How do you know this?

    f. How has the project done this? If you had to choose: which one activity

has made the most difference in the quality of maternal and child health services?

g. Do you think these improvements in quality will continue after the project ends? Why do you think this?

a. **<u>If YES</u>**: Which improvements/changes are likely to continue?

(2) **<u>If NO</u>**: What could the project have done differently to improve the quality of maternal and child health services?

<u>Scale-up and Sustainability</u>

11. In addition to what you have already mentioned, what other positive effects or impact of the project will remain after the project ends? (***Probe: What will continue?***)
12. What aspects of the project might the Ministry of Health scale up? (***Probe for examples such as the MSG, m-PWS, use of the SBMR tool, increased allocation of resources for maternal and child health, etc.)***
    a. Ask specifically about MSG: What will be the main challenges for scaling up MSG? (***Probe: Political will? Willingness of the Puskesmas to support the MSG? Community support? Human and financial resources? Etc***.)

        (1) Do you know if there are concrete plans for scaling up? Please describe.

    b. ***If NO scale-up of anything is planned***: Why not?

13. Exit strategy: Has the project informed all the communities and partners that it will be ending?

    a. **<u>If YES</u>**: When did it start informing them? How did it inform them?

<u>Learning and Adaptation</u>

14. How does the project share results and lessons learned with:

    a. The project staff?

b. The MHO and with other Ministry of Health structures such as the Provincial Health Office?
c. Other organizations working in health (NGOs, UNICEF, etc.)?

15. Please tell me what you think about m-PWS. (***Probe: What do you like about it? What don't you like about it?***)

a. Do you think m-PWS can be scaled up?

If YES:

(1) What is needed to scale it up? (***Probe: Political will? Willingness of the Puskesmas to support the MSG? Community support? Human and financial resources? Etc***.)

If NO:

(2) Why not? What would make it difficult to scale it up?

16. If an organization or the Ministry of Health wants to start a project similar to Hati Kami, what are the strong points of this project that should be replicated?
17. And what should they do differently? What changes would you propose for such a program? (***Probe: What were the weaknesses?)***

Thank you very much for agreeing to spend time with us and for your comments. We appreciate it.

*Signature of interviewer:*_____ *Date:*_____

*Signature of reporter:*_____ *Date:*_____

*Reviewed by:*_____ *Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

INDIVIDUAL INTERVIEW GUIDE FOR

IBI LEADERS **(Indonesian Midwives Association)**

(Participants are staff in a leadership position at the IBI who have worked closely with the Hati Kami project.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out how you have been working with the Hati Kami project and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	September 2014
Name of Interviewer	
Name of Reporter	
Interview Time	Started: Ended:
Position of participant(s)	

General Information

1. Can you tell me a little about your responsibilities in the IBI?
2. What is your understanding of the purpose of the Hati Kami (Mercy Corps health project?)
3. What have been the key achievements of the project to date?

Collaboration

4. What is your connection/relation/association with the project?
5. What activities have you participated in?
6. What have been IBI's contributions to the project?
7. Has IBI gained anything from its collaboration with the project? (advantages of collaborating with the project)

    a. **If YES**: Please describe what IBI has gained (the advantages of collaborating).

    b. **If NO**: Why not? (***Probe: Has the collaboration taken up too much of their time? Has it added to their workload? etc.)***

8. Has the project helped the IBI achieve its own objectives/targets/plans/goals?

    a. **If YES**: Please describe how the project has helped the IBI.

Community Engagement

9. Has the project contributed to getting the community more involved in maternal and child health and nutrition?

    a. **If YES**: How has this been done? (***Probe: How have the following activities helped the community members to be more involved in maternal and child health and nutrition: The MSG? Training private and public midwives? Training community members to be advocates for increased funding for MCH and nutrition? Involving religious leaders?***)

    b. And has involving the community contributed to better health outcomes for women and children?

(1) How do you know this?

(2) How exactly has involving the community contributed to better health outcomes?

c. ***(If the response is NO, the project has not involved the community – clarify that there has been no community involvement.)***

Service Delivery/Quality

10. Has the project helped improve the skills and compliance of midwives?

If YES:

a. How do you know this?
b. How has the project helped improve their skills and compliance?
c. Do you think these changes will be sustained? Why or why not?

11. Has the project helped improve the quality of maternal and child health services?

If YES:

a. How do you know this?
b. How has the project done this? What specific activities have made a difference in the quality of maternal and child health services? [***Probe for MSG, training, use of the SBMR tool, the m-PSW, other capacity building activities, etc.***
c. Do you think these improvements in quality will continue after the project ends? Why do you think this?

(1)If YES: Which improvements/changes are likely to continue?

b. If NO: What could the project have done differently to improve the quality of maternal and child health services?

Scale-up and Sustainability

12. In terms of sustainability: What positive effects or impact of the project will remain after the project ends? (***Probe: What will continue?***)

a. What aspects of the project might be scaled up? (***Probe for examples***

such as the MSG, m-PWS, use of the SBMR tool, etc.)

(1) For the MSG: What is needed for the MSG to be scaled up?

Learning and Adaptation

13. Has the project shared results and lessons learned with IBI?

If YES:

a. Please give examples of occasions when the project shared results and lessons learned. How has the project shared?

b. Did this information lead to any changes in policies or strategies or approaches?

If YES:

(1) Please give some examples of how lessons learned and results from the project led to changes.

14. Please tell me about your opinion of the m-PWS technology. (***Probe: What do you like about? What don't you like about it?***)

15. Has m-PWS helped public and private midwives in their work?

a. **If YES**: How?

b. **If NO**: How could m-PWS be changed to be more helpful to you and to the midwives?

16. Do you think m-PWS can be scaled up?

If YES:

a. What is needed to scale it up?

If NO:

b. Why not? What would make it difficult to scale it up?

17. If any party wants to start a program similar to Hati Kami, what are the strong points of this project that should be replicated?)

18. And what should they do differently? What changes would you propose for such a program? (***Probe: What were the weaknesses?)***

Thank you very much for agreeing to spend time with us and for your comments.

*Signature of interviewer:*_____ *Date:*_____

*Signature of reporter:*_____ *Date:*_____

*Reviewed by:*_____ *Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

INDIVIDUAL INTERVIEW GUIDE FOR

MENTORS

(Participants are PKK members who are Mentors to the MSG Motivators.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out how you have been working with the Hati Kami project and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	September 2014
Name of Interviewer	
Name of Reporter	
Number of Motivators the Mentor is responsible for	
Interview Time	Started: Ended:

General Information

1. What is your understanding of the purpose of the Hati Kami (Mercy Corps health project?)

Collaboration

2. I understand that you are a Mentor for MSG Motivators. How long have you been a mentor?

   ___ Less than 1 year
   ___ 1-2 years
   ___ More than 2 years

3. Please tell me what your role and responsibilities as a Mentor are.
4. Did you receive any training or orientation on how to be a Mentor?

   a. **If YES:** Please describe the training (length, topics, who conducted it).

5. Do you have any other responsibilities within the project? (***Probe for breastfeeding counselor, SBMR, etc.***)
6. About how often do you meet with each Motivator on an individual basis?
7. Can you give me some examples of the challenges the Motivators face in their work and some specific examples of how you have helped individual Motivators with these challenges?
8. What challenges do you yourself face in your work as a Mentor?
9. Why did you accept to become a Mentor?

Community Engagement

10. Has the project contributed to getting people in the community more involved in maternal and child health and nutrition?

    a. If YES: How has this been done? (***Probe: How have the following activities helped the community members to be more involved in maternal and child health and nutrition: The MSG? Training private and public midwives? Training community members to be advocates for increased funding for MCH and nutrition? Involving religious leaders?***)

b. And has this contributed to better health for women and children?

(1) How do you know that the health of women and children has improved? (Refers to their response to b. above.)

11. Can you tell me a little about how the PKK has helped communities advocate for increased funding for some MSG activities at the sub-district level?

12. Do you think this advocacy work will continue? Who will continue it?

Service Delivery/Quality

13. Do you think the project has helped to improve the quality of MCH and nutrition services?

If YES:

a. Why do you think so?

b. How has the project helped to improve the quality of services? Please provide some examples of specific activities. (***Probe: training? Use of new tools? Use of technology such as m-PWS?)***

Scale-up and Sustainability

14. In terms of sustainability: What positive effects or impact of the project will remain after the project ends? (***Probe: What will continue?***)
15. If the Ministry of Health or another organization wants to start a program similar to Hati Kami, what are the **strong points** of this project that should be included?)
16. And what should they do differently? What changes would you propose for such a program? (***Probe: What were the weaknesses?)***

Thank you very much for agreeing to spend time with us and for your comments.

*Signature of interviewer:*_____ *Date:*_____

*Signature of reporter:*_____ *Date:*_____

*Reviewed by:*_____ *Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

INDIVIDUAL INTERVIEW GUIDE FOR

MUNICIPAL HEALTH OFFICE

(Participants are staff at the MHO who have worked closely with the Hati Kami project.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are conducting a survey to find out how you have been working with the Hati Kami project and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	September 2014
Name of Interviewer	
Name of Reporter	
Interview Time	Started: Ended:
Position of participant(s)	Women: Men:

General Information

1. Can you tell me a little about your responsibilities in the MHO?
2. What is your understanding of the purpose of the Hati Kami (Mercy Corps health project)?

Collaboration

3. What is your connection/relation/association with the project? (***Probe: What is his/her contribution to the project?***)
4. What have been the key achievements (visible results) of the project to date?
5. How is this project different from other projects (especially other NGO projects)?
6. Has the MHO gained anything from its collaboration with the project? (advantages of collaborating with the project)

    a. **If YES**: Please describe what the MHO has gained (the advantages of collaborating).
    b. **If NO**: Why not? (***Probe: Has it taken up too much of their time? Has it added to their workload? etc.)***

7. Has the project helped the MHO achieve its own objectives?
    a. If YES: Please describe how the project has helped the MHO.

Community Engagement

8. Has the project contributed to getting the community more involved in maternal and child health and nutrition?

    a. **If YES**: How has this been done? (***Probe: How have the following activities helped the community members to be more involved in maternal and child health and nutrition: The MSG? Training health care providers? Training community members to be advocates for increased funding for MCH and nutrition? Involving religious leaders?***)

    b. And has involving the community contributed to better health outcomes for women and children?

        (1) How do you know this?

(2) How exactly has involving the community contributed to better health outcomes?

c. (If the response is NO, the project has not involved the community – clarify that there has been no community involvement.)

9. Are the Puskesmas in your municipality doing things differently in MCH health and nutrition as a result of their collaboration with the project?

<u>If YES</u>:

a. What are they doing differently?

b. How do you think these changes influence the health and nutrition of women and young children?

c. Was it difficult for the Puskesmas to make these changes? (***Probe: Were there challenges and barriers to overcome in making these changes?)***

d. Will these changes continue after Hati Kami ends?

(1)**<u>If YES</u>**: Explain why you think so.

(2) **<u>If NO</u>**: Why not?

<u>Service Delivery/Quality</u>

10. Has the project helped improve the skills and compliance of health care providers?

<u>If YES</u>:

a. How do you know this?
b. Which health care providers has the project helped? (***Probe for private midwives too.)***
c. How has the project helped improve their skills and compliance?

11. Has the project helped improve the quality of maternal and child health services?

    <u>If YES:</u>
    a. How do you know this?
    b. How has the project done this? What specific activities have made a difference in the quality of maternal and child health services? [***Probe for MSG, training, use of the SBMR tool, the m-PSW, other capacity building activities, etc.***

12. Do you think these improvements in quality will continue after the project ends? Why do you think this?

    a. **<u>If YES</u>**: Which improvements/changes are likely to continue?

    b. **<u>If NO</u>**: What could the project have done differently to improve the quality of maternal and child health services?

<u>Scale-up and Sustainability</u>

13. Did the project have any influence on how the communities, the Puskesmas and the Ministry of Health in general allocate resources for maternal and child health and nutrition?

    <u>If YES</u>:
    a. Please describe what has changed in the allocation of resources. (***Probe: If there was an increase in resources for maternal and child health and nutrition, ask about how much more was allocated, for what budget year, etc***. ***Could also ask about the musrenbang process***.)

    b. Do you think this change in resource allocation will be continued? Why or why not?

14. In addition to what you have already mentioned, what other positive effects or impact of the project will remain after the project ends? (***Probe: What will continue?***)

15. What aspects of the project might the MHO scale up? (***Probe for examples such as the MSG, m-PWS, use of the SBMR tool, increased allocation of***

resources for maternal and child health, etc.)

a. **<u>For the MSG</u>**: Will this approach be scaled up in your municipality? In other areas?

<u>If YES</u>:

(1) What will be the main challenges for scaling up the MSG approach? (***Probe: Political will? Willingness of the Puskesmas to support the MSG? Community support? Human and financial resources? Etc***.)

(2) What is needed for the MSG to be scaled up?

(3) Are there concrete plans for scaling up? Please describe.

b. ***If NO scale-up of anything is planned***: Why not?

16. What aspects of the project might the **<u>Provincial</u>** Health Office be interested in scaling up?

<u>Learning and Adaptation</u>

17. Has the project shared results and lessons learned with the MHO and with other Ministry of Health structures such as the Provincial Health Office?

<u>If YES</u>:

a. Please give examples of occasions when the project shared results and lessons learned. How has the project shared?

b. Did this information lead to any changes in policies or strategies or approaches?

<u>If YES</u>:

(a) Please give some examples of how lessons learned and results from the project led to changes.

18. Please tell me what you think about m-PWS. (***Probe: What do you like about it? What don't you like about it?***)

19. From what you know about m-PWS, how could it help the MHO in its work?
20. Do you think m-PWS can be scaled up?

If YES:

(a)What is needed to scale it up? (***Probe: Political will? Willingness of the Puskesmas to support the MSG? Community support? Human and financial resources? Etc***.)

If NO:

(b) Why not? What would make it difficult to scale it up?

21. If any party wants to start a project similar to Hati Kami, what are the strong points of this project that should be replicated?
22. And what should they do differently? What changes would you propose for such a program? (***Probe: What were the weaknesses?)***

Thank you very much for agreeing to spend time with us and for your comments. We appreciate it.

*Signature of interviewer:*_____*Date:*_____

*Signature of reporter:*_____*Date:*_____

*Reviewed by:*_____*Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

INDIVIDUAL INTERVIEW GUIDE FOR

PRIVATE MIDWIVES

(Participants are private midwives who have been involved with the project. They may have been trained in MSG mentorship, SBMR, Breastfeeding Counseling, and/or they may be participating in m-PWS.)

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out what you know about the Hati Kami project (the Mercy Corps health project) and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	September 2014
Name of Interviewer	
Name of Reporter	
Kecamatan *District*	
Kelurahan *Sub-District*	
RW	
Interview Time	Started: Ended:

General Information

1. Can you tell me a little about your experience as a midwife – how long you have been a midwife, how many women you see on average every day, what you enjoy about being a midwife?
2. What is your understanding of the purpose of the Hati Kami project/ Mercy Corps work?

Collaboration

3. What is your involvement in the project?

   I am a (circle all that apply; may be more than one response):

   a. Breastfeeding counselor
   b. MSG mentor
   c. SBMR participant
   d. mPWS midwife
   e. Other (specify)……..

4. Have you gained anything from collaborating with the project (advantages of collaborating with the project)?

5. **If YES**: What have you gained?

Community Engagement

6. Did you acquire new skills or knowledge from your work with Hati Kami?

   a. **If YES**: Please give me some examples.

7. Have the new skills or knowledge had any impact or result on the health of the women and children you take care of?

   …….. Yes
   …….. No

If YES:

a. How do you know this?
b. What are the impact/results on the health of the women and children?

8. After Hati Kami ends, will you continue to practice what you have learned?

If YES:
a. What will you continue to practice/do?
b. What are the challenges you might face in continuing those practices?
c. **If NO**: Why not?

9. What are the challenges you might face in continuing those practices?

BCC

10. What are the key messages you promote on maternal and child health? What are the main practices and behaviors you encourage?
11. Do the women hear the same messages on breastfeeding from other sources of information?

a. **If YES**: What are the other sources? [**Do not read the answers below**.]

__ Other activity
(Ask for name of activity) _____
__Health care providers at Puskesmas
__Private health care providers
__Radio
__TV
__Posters
__ Other (Specify: _____)

12. Do the women hear the same messages on maternal nutrition from other sources of information?

a. **If YES**: What are the other sources? [**Do not read the answers below**.]

__ Other activity
(Ask for name of activity) _____
__Health care providers at Puskesmas
__Private health care providers
__Radio
__TV
__Posters
__ Other (Specify: _____)

13. Of these practices/behaviors that you promote: Which are the easiest for the women to adopt? (What changes are easiest?)
    a. Why do you think this is so?
    b. How do you know the women have changed their practices?

14. Which practices/behaviors are the most difficult for women to change/adopt?
    a. What prevents them from changing/what are the barriers?
    b. What solutions can you propose to overcome these barriers?

Service Delivery/ Quality

15. Has Hati Kami helped improve the quality of maternal and child health services?

____ Yes
____ No

If YES:

a. How do you know this?
b. How has the project done this? What specific activities have they supported? [***Probe for training, use of the SBMR tool, the m-PSW, etc.***]
c. Do you think these improvements will continue after the project ends?

____ Yes
____ No

d. Why do you think this?

If NO:

a. What could the project have done differently to improve the quality of maternal and child health services?

If the midwife is participating in m-PWS, ask the following questions:

16. What is your opinion of the m-PWS (model)?
(***Probe: What do you like about m-PWS? What don't you like about it?***)

17. Has m-PWS helped you in your work?

If YES:

a. How?
b. Could m-PWS be improved to be more helpful to you/easier to use? How?

If NO: (If m-PWS has not helped her in her work)

c. How could m-PWS be changed to be more helpful to you?

18. Do you plan to continue using m-PWS?

If YES:

a. Why?
b. Will you need any support to be able to continue using this technology?
c. What support?

If NO:

d. Why not?

e. Do you think m-PWS is something that can be scaled up for other health care providers to use?

If YES:

(1) For what health care providers?
(2) What steps would need to take place to scale it up?

If NO:

(3) Why not? What would make it difficult to scale it up for other health care providers?

Thank you very much for agreeing to spend time with us and for your comments. We appreciate it.

*Signature of interviewer:*_____*Date:*_____

*Signature of reporter:*_____*Date:*_____

*Reviewed by:*_____*Date:*_____

HATI KAMI ENDLINE QUALITATIVE EVALUATION

INDIVIDUAL INTERVIEW GUIDE FOR

***STAFF AT PUSKESMAS* (PHC)**

(Participants are Head and/or staff (coordinating midwife, nutritionist, General Physician) of Puskesmas in the project area.

INFORMED CONSENT

Good morning/afternoon. My name is _____ and my colleague's name is _____. We are working with Mercy Corps and the Municipality of Health Office, Department of West Jakarta. We are conducting a survey to find out how you have been working with the Hati Kami project and what you think about it. This information will assist the government and Mercy Corps to understand the impact of the project and how health services can be improved in the future. The interview will last approximately _____. The information that you provide will be kept confidential.

Participation in these surveys is voluntary and you can refuse to answer questions or to not continue the interview. We hope you will choose to participate because your opinion is very important to us. Now, would you like to participate? May I start this interview/discussion?

Date	September 2014
Name of Interviewer	
Name of Reporter	
Kecamatan *District*	
Kelurahan *Sub-District*	
Interview Time	Started: Ended:
Position of participant(s)	Head of Puskesmas _____ (male/ female) Coordination Midwife_____(male/ female) Other staff (specify) _____(male/ female) _____ (male/ female)

General Information

1. Can you tell me a little about how long you have been working at this Puskesmas and what your responsibilities are?
2. What can you tell me about the Hati Kami or Mercy Corps Health project? What is the purpose of the project?

Collaboration

3. What is your involvement with the project?
4. Have you gained anything from collaborating with the project? (advantages of collaborating with the project?)

    a. **If YES**: Please describe what you have gained from collaborating with the project (the advantages of collaborating with the project.)

    b. **If NO**: Why not? (***Probe: Has it taken up too much of their time? Has it added to their workload? etc.)***

5. Have you participated in any training that the project helped to organize?

    a. **If YES**: Please describe the type of training (topic of training)

Community Engagement

6. Is this Puskesmas now doing things differently than before the project started?

    a. **If YES**: Please give me some examples.

7. What impact or result, if any, have these changes had on the Puskesmas' catchment area, especially on the health of the women and children here?

    a. How do you know this?

8. What is the probability that you will continue what you have been doing with the project (***refer back to #6***)?

9. What are the constraints? What might make it difficult for you to continue?

BCC

10. Are you promoting any new messages since you started working with the project?

    a. **If YES**: What messages?

Service Delivery/Quality

11. Has the project helped improve the quality of maternal and child health services in your catchment area?

    If YES:

    a. How do you know this?
    b. How has the project done this? What specific activities have they supported? [***Probe for training, use of the SBMR tool, the m-PSW, etc.***]
    c. Do you think these improvements will continue after the project ends? Why do you think this?
    d. What needs to be in place for these improvements to continue? (***Ask about each one they mentioned: use of the SBMR tool, the m-PSW, etc. What resources, support, etc. will they need to continue these activities?***)

    If NO (no improvements in quality of services):

    e. What could the project have done differently to improve the quality of maternal and child health services?

Sustainability

12. Did the project have any influence on how this Puskesmas allocates resources for maternal and child health and nutrition?

    a. **If YES**: Please describe how you have changed your allocation of resources. (***Probe: If there was an increase in resources for maternal and child health and nutrition, ask about how much more was allocated, for what budget year, etc***.)

13. If you or any other party wants to start a similar program such as Hati Kami, what elements of the current program should they keep? (***Probe: What are the strong points of this project?***)

14. And what should they do differently? What changes would you propose for such a program? (***Probe: What were the weaknesses?)***

<u>If the staff is participating in m-PWS, ask the following questions</u>:

15. Please tell me about your experience with m-PWS.
16. What is your opinion of m-PWS? (***Probe: What do you like about it? What don't you like about it?***)
17. Has it helped you in your work?

<u>If YES</u>:

a. How?
b. Could m-PWS be improved to be more helpful to you/easier to use? How?

<u>If NO</u>:

c. How could m-PWS be changed to be more helpful to you?

18. Do you plan to continue using m-PWS?

<u>If YES</u>:

a. Why?
b. Will you need any support to be able to continue using m-PWS
c. What support?

<u>If NO</u>:

d. Why not?

19. Do you think m-PWS is something that can be scaled up for other health care providers to use?

<u>If YES</u>:

a. For what health care providers?
b. What steps would need to take place to scale it up?

<u>If NO</u>:

c. Why not? What would make it difficult to scale it up for other health

care providers?

Thank you very much for agreeing to spend time with us and for your comments. We appreciate it.

*Signature of interviewer:*_____*Date:*_____

*Signature of reporter:*_____*Date:*_____

*Reviewed by:*_____*Date:*_____

ANNEX XI. SOURCES OF INFORMATION

A. Principal documents reviewed

1. CSHGP Final Evaluation Guidelines (FY13)
2. Scope of Work for Final Evaluation
3. CSHGP Learning Themes Presentation (PowerPoint prepared by EnCompass)
4. Proposal Narrative
5. KPC Baseline Survey Report
6. Maternal Nutrition Baseline Survey Report
7. Detailed Implementation Plan
8. Annual Report Year 2 with Annexes
9. Annual Report Year 3 with Annexes
10. Report: Main Findings of LQAS (midterm)
11. Operations Research Concept Paper/Design
12. Operations Research: Baseline Survey Report
13. Operations Research: Midterm Report
14. *Draft* Operations Research Final Report
15. Technical Assistance Reports
    a. Judiann McNulty: November-December 2012
    b. Jennifer Norman: Follow-up on Action Plan (March 2013)
    c. Jennifer Norman: Recommendations (June 2013)
16. Hati Kami Program Learning Briefs
    a. Operations Research
    b. Mothers Support Groups
    c. *Musrenbang*
17. MCH from an Islam Perspective (book, brochures, booklet – reviewed with translator)
18. DHS Indonesia 2012

B. People interviewed

Respondents	Total Interviewed	Instrument	Interviewer(s)
MSG participants	8 groups	FGD	Project staff with external partners
MSG Motivators	8 groups	FGD	Project staff with external partners
Community leaders and CHWs involved in m-PWS	1 group	FGD	Lead evaluator
MSG Mentors	4	KII	1 by lead evaluator, 3 by project staff
Private midwives	4	KII	Lead evaluator, other external consultant
PHC staff	Staff from 6 PHCs	KII	Lead evaluator, other external consultant

Municipality Health Office (Director of Public Health, MCH Program Coordinator)	2	KII	Lead evaluator
Indonesian Midwives Association	1	KII	Lead evaluator
Public Health Director, Mercy Corps HQ (Jennifer Norman)	1	KII	Lead evaluator
Consultant (Judiann McNulty)	1	KII	Lead evaluator
Hati Kami project staff (all)	11	KII	Lead evaluator
Mercy Corps Indonesia Country Director (Paul Jeffery)	1	KII	Lead evaluator
Mercy Corps Indonesia Finance Director (Sandy Mukhlisin)	1	KII	Lead evaluator

ANNEX XII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Kathy Tilford
Title	
Organization	Independent Consultant
Evaluation Position	Lead Evaluator
Evaluation Award Number	USAID Cooperative Agreement No. AID-OAA-A-10-00063
USAID Project Evaluated	Hati Kami Project, Jakarta, Indonesia
I have real or potential conflicts to disclose	No

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	October 1, 2014

ANNEX XIV. EVALUATION TEAM MEMBERS, ROLES AND THEIR TITLES

NAME	TITLE	ROLE
EXTERNAL CONSULTANTS		
Kathy Tilford	Independent Consultant	Lead evaluator
Shaula Bellour	Independent Consultant	Interviewer for certain KIIs
EXTERNAL PARTNERS		
Friana Sinambela	Secretary of the West Jakarta IBI (Indonesian Midwives Association)	FGD Facilitator
Erna Gernasih	Head of the Maternity Ward at the Cengarent District PHC	FGD Facilitator
Evi Rimahayani Pane	Nutrition Coordinator at the Kalideres District PHC	FGD Facilitator
Roro Eka Agustini	Nutritionist – West Jakarta Municipality Health Office	FGD Facilitator
HATI KAMI PROJECT STAFF		
Sri Kusuma Hartani	Health and Nutrition Program Manager	KII Facilitator
Dr. Muhammed Ali	Government and Clinical Liaison Officer	KII Facilitator
Ellen Simanungkalit	District Coordinator	FGD Facilitator

Asep Hepiana	District Coordinator	FGD Facilitator
Farida Ayu Erikawati	Health and Nutrition Technical Strengthening Leader	FGD Facilitator
Fajar R. Hiya	Junior District Coordinator	FGD Facilitator
Gunawan Meliyandoko	M&E Specialist	KII and FGD Facilitator
Didit Agus I.	LAMAT (OR) Coordinator	KII and FGD Facilitator
Ab. Jabbar	District Coordinator	KII and FGD Facilitator
Pariama Novayanti Siburian	OR Assistant	KII and FGD Facilitator
Sari Cahyati	Program Admin Officer	Admin and Logistical Support

FINAL RESULTS OF THE HATI KAMI PROJECT

ANNEX XVII.

STAKEHOLDER DEBRIEF POWERPOINT PRESENTATION

PRESENTATION FOR STAKEHOLDERS
SEPTEMBER 19, 2014
JAKARTA

THE HATI KAMI PROJECT

- **Nurturing the Mother Child Dyad,** a project to promote, support, and protect the mother-child dyad for a healthy start among Jakarta's poor residents.
- Direct beneficiaries: 8,558 pregnant women and 7,723 infants
- Dates: September 30, 2010 – September 29, 2014
- Location: 8 Sub-districts in the West Jakarta Districts of Cengkareng and Kalideres
- Principal organizational partners: The West Jakarta MHO, the PHO, District and Sub-district Puskesmas, IBI, PKK, and the University of Indonesia Center for Family Welfare

USAID DARI RAKYAT AMERIKA

JAYA RAYA

IKATAN BIDAN INDONESIA

Mercy Corps Indonesia

EVALUATION QUESTIONS & THEMES

Key Evaluation Questions from the SOW:

- To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the DIP?
- What were the key strategies and factors, including management issues, that contributed to what worked or did not work?
- Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?
- What are stakeholder (community members, Municipality Health Office) perspectives on the OR implementation, and how did the OR study affect capacity, practices, and policy?

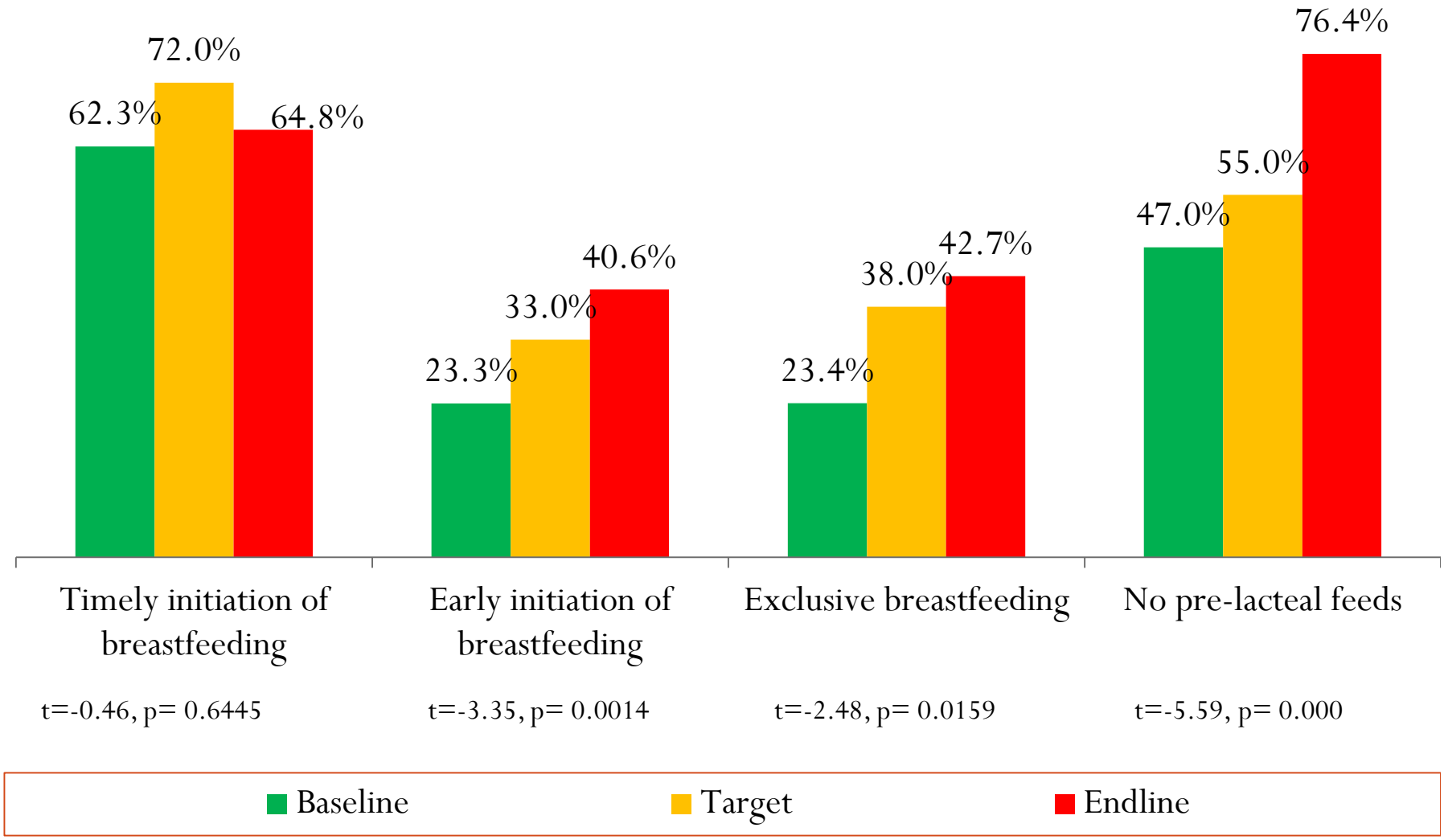
Learning Themes for CS Final Evaluations:

- Community Involvement
- Service Equity and Quality
- Scale Up and Sustainability
- Learning and Adaptation, including Operations Research

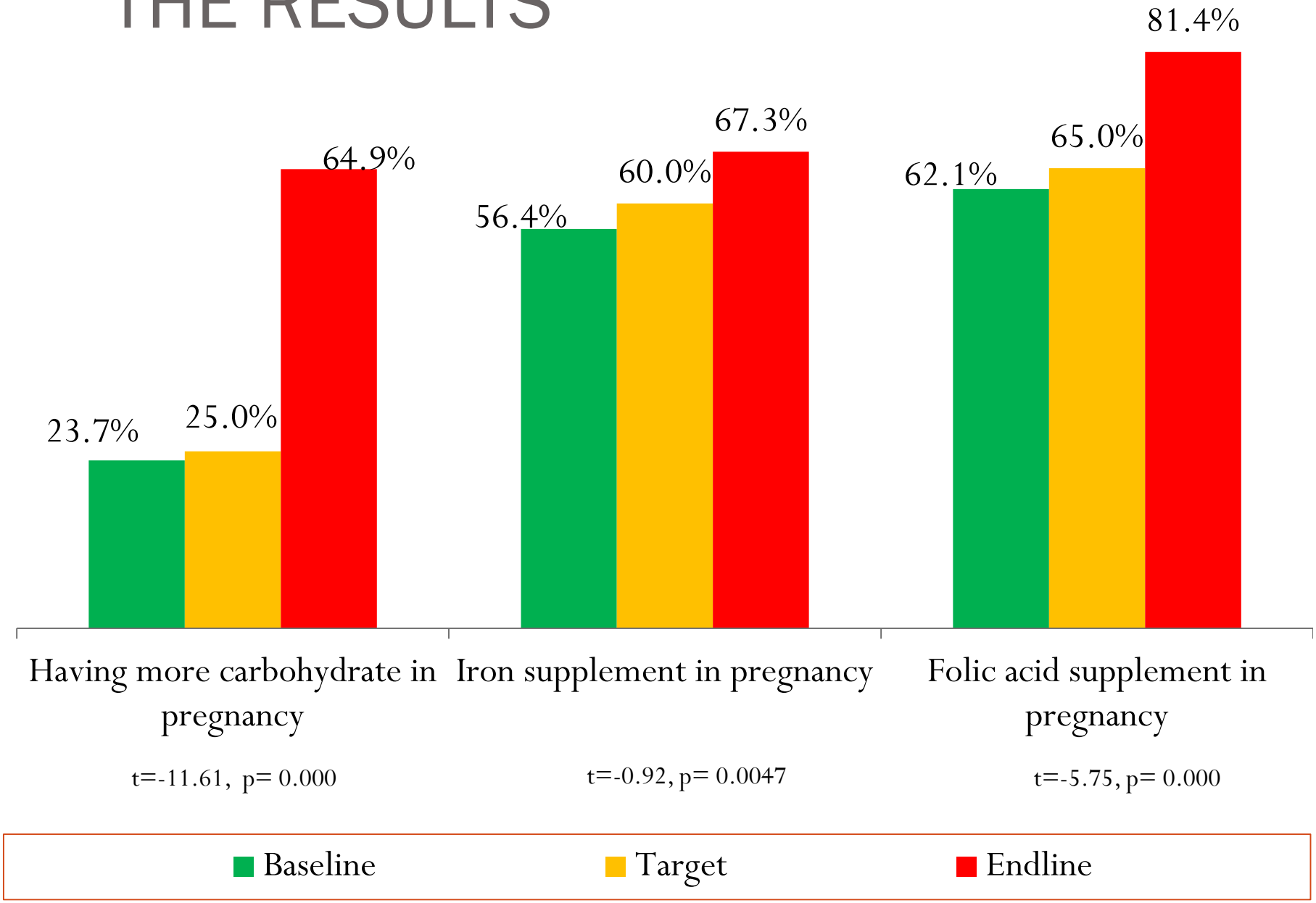
QUANTITATIVE RESULTS

- Two population-based surveys (repeating the baseline survey):
  - KPC Survey on Maternal Nutrition
  - KPC Survey with mothers of children 0-23 month
- Sample: pregnant women and mothers of children 0-23 months from 8 Sub-districts of Cengkareng and Kalideres District.
  - Total sample for Maternal Nutrition Survey: 575
  - Total sample for Mothers of children 0-23 months: 330.
  - Cluster sampling method was applied for both surveys. Clusters are the community neighborhood unit (RW). Clusters are selected through random PPS process.
- Two assessments of health service providers:
  - Puskesmas (16) and hospitals (4)
  - Private midwives (25)

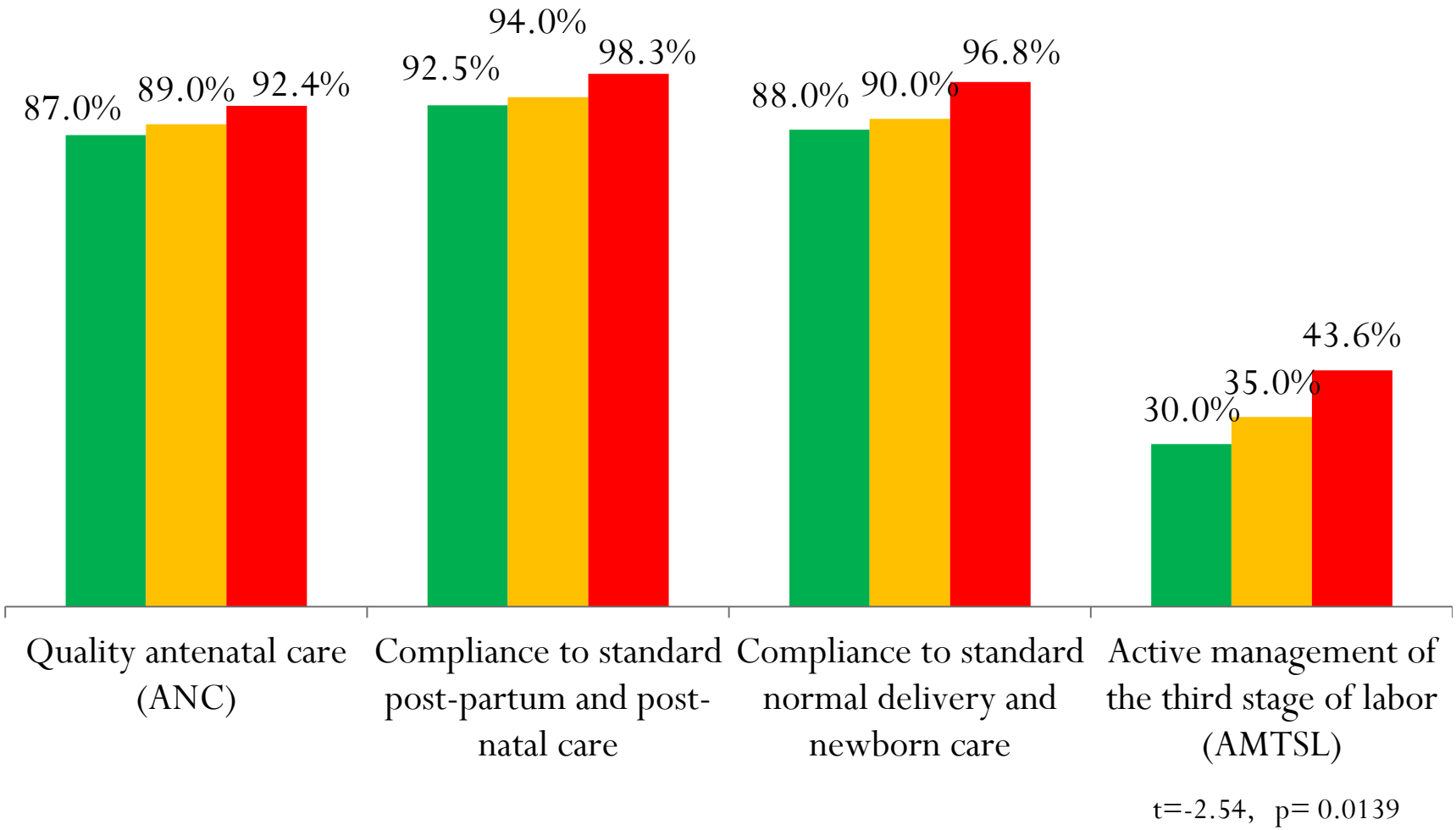
THE RESULTS


62.3%
72.0%
64.8%
23.3%
33.0%
40.6%
23.4%
38.0%
42.7%
47.0%
55.0%
76.4%
Timely initiation of breastfeeding
Early initiation of breastfeeding
Exclusive breastfeeding
No pre-lacteal feeds
t=-0.46, p= 0.6445
t=-3.35, p= 0.0014
t=-2.48, p= 0.0159
t=-5.59, p= 0.000
Baseline
Target
Endline

THE RESULTS


23.7%
25.0%
64.9%
56.4%
60.0%
67.3%
62.1%
65.0%
81.4%
Having more carbohydrate in pregnancy
t=-11.61, p= 0.000
Iron supplement in pregnancy
t=-0.92, p= 0.0047
Folic acid supplement in pregnancy
t=-5.75, p= 0.000
Baseline
Target
Endline

THE RESULTS


87.0%
89.0%
92.4%
92.5%
94.0%
98.3%
88.0%
90.0%
96.8%
30.0%
35.0%
43.6%
Quality antenatal care (ANC)
Compliance to standard post-partum and post-natal care
Compliance to standard normal delivery and newborn care
Active management of the third stage of labor (AMTSL)
t=-2.54, p= 0.0139
Baseline
Target
Endline

QUALITATIVE RESULTS

METHODOLOGY:

❖ **Focus Group Discussions with:**

- Participants in Mothers Support Groups (MSGs)
- MSG Motivators
- Volunteers and community leaders implementing m-PWS

❖ **Key Informant Interviews with:**

- Puskesmas Staff
- MHO
- IBI
- Private midwives
- Mentors for MSG Motivators
- Project Staff
- Technical assistance providers: Mercy Corps HQ, Consultant

1. COMMUNITY ENGAGEMENT

- MSGs: an effective forum for reaching people (especially women) with the right information
- Project facilitated access to the community for the Puskesmas, leading to higher attendance, better knowledge of population and its problems and greater achievement of Puskesmas targets
- Project brought private midwives closer to potential clients. One midwife said: “I have become closer to the community.”
- Partnership with PKK provided credibility and a larger audience for Hati Kami activities.

COMMUNITY ENGAGEMENT

- Involving the community, especially RT and RW leaders, resulted in increased local funding for maternal and child health activities.
- Community volunteers and leaders highly visible in Operations Research activities, building capacity for data collection and analysis.
- Effective strategies for community engagement included: networking (e.g., PKK); training and capacity building for community health volunteers and community leaders; creating MSGs; and reinforcing public/private partnerships by involving private midwives

2. SERVICE DELIVERY AND QUALITY

- Increased use of service (sources: Puskesmas staff and beneficiaries)
- Quality improvements in services, especially for pregnant women and newborns both at Puskesmas and from private midwives (endline surveys and assessments)
- Strategies to ensure equitable access and to improve quality included: BCC via MSGs; use of improved data to locate pregnant women and mothers of children 0-23 months; training in maternal and neonatal care for public and private providers; introduction of SBMR, a self-monitoring tool for midwives; leveraging ongoing funding for maternal and child health services; and reinforcing the effective partnership with IBI.

3. SCALE UP AND SUSTAINABILITY

- Scaled up MSG
- Trained Motivators, Mentors, religious leaders, and community volunteers and leaders to ensure continuation of MSGs with oversight and support from Puskesmas
- Introduced SBMR to West Jakarta and now being scaled up by MHO and IBI for lasting improvement in quality health care
- Piloted use of mobile technology for LAMAT and MHO planning to scale up
- Trained community leaders and other stakeholders to lobby effectively for increased local funding for MCH
- Developed manuals for MSG; mobile technology; and religious leaders to enhance continuation of project impact

4. LEARNING AND ADAPTATION

- Operations Research:
  - Rawa Buaya Puskesmas: Likes m-PWS and wants it to replace the manual system; provides real time data, can cross-check, more accurate population data facilitates access to pregnant women and children < 2
  - Other Puskesmas want to try m-PWS
  - MHO committed to scaling up for west Jakarta

- Monitoring and evaluation:
  - Gradually transfer/ institutionalize capacities to strengthen and make informed-decision upon community-based health activity (i.e. MSG); private midwife practices (i.e. SBMR, Breastfeeding Counseling, SBMR follow-up refresher course); and health-friendly budgeting.

SUCCESS FACTORS

- Careful attention to cultivating strong working relationships with organizational partners
- Excellent support from all major organizational partners
- Tightly focused project with interconnected objectives and activities that respond to priorities of MoH
- Project design built on lessons learned from previous breastfeeding project in Jakarta

SUCCESS FACTORS

- Timeliness of concrete actions for sustainability
- Helping health centers reach targets ensured their support and participation
- Improved social cohesion encouraged beneficiary participation
- Commitment of key individuals (champions) helped overcome roadblocks
- Closely-knit project team with complementary skill sets
- Ability of project to adapt and try out innovative solutions

LESSONS LEARNED & RECOMMENDATIONS FOR FUTURE PROJECTS

- Gender: Develop a broader approach to reach and involve husbands and fathers.

- BCC: Enlarge the scope of the BCC component, including the recommendations made at the midterm assessment.

LESSONS LEARNED & RECOMMENDATIONS FOR FUTURE PROJECTS

- MSGs: Introduce topics such as IYCF earlier in the project.
- Pregnant women:
  - Improve outreach to pregnant women to ensure that they receive counseling through MSGs and/or providers.
  - Increase the number of health care providers trained in counseling.
- Leaders: Recruit more women religious leaders and wives of RT/RW leaders to be MSG Motivators

RECOMMENDATION FOR STAKEHOLDERS

- **Health Offices (Municipality & Province)**
  - Strengthen policy that further enables/reinforce the establishments of MSG (there is a *Surat Keputusan Kepala Dinas Kesehatan* on *10 LMKM*)
  - Maintain and expand relationship with pool of resource persons (e.g. IKMI, other training institutions, etc.) to enrich SBMR follow ups (e.g. refresher seminar, courses, etc.)

RECOMMENDATION FOR STAKEHOLDERS

- **PUSKESMAS**
  - A binding agreement (MoU) between Puskesmas and Private Midwives for collaborative technical support to MSG

- **Ikatan Bidan Indonesia** (IBI – Indonesian Midwives Association)
  - Breastfeeding Counseling as mandatory competency for private midwife (old & new)
  - In concert with MHO roll out SBMR from checklist –> appraisal –> mentorship by IBI leadership

RECOMMENDATION FOR STAKEHOLDERS

- **PKK** (Civil society organization)
  - For trained champions, stay tuned for pre-Musrenbang timeline (October – December cycle)
  - Strengthen relationship with Public Health Officer at the sub-district government (*Kesehatan Masyarakat Kantor Kelurahan)*
- **Community Leaders**
  - Continue budgeting for MSG through Musrenbang
  - Optimize use of MCH topics (verbal, video, etc.) in casual and formal community gatherings.

ANNEX XVIII. PROJECT DATA FORM

Child Survival and Health Grants Program Project Summary

Sep-27-2014

Mercy Corps (Indonesia)

General Project Information

Cooperative Agreement Number:	AID-OAA-A-10-00063
MC Headquarters Technical Backstop:	Jennifer Norman
MC Headquarters Technical Backstop Backup:	
Field Program Manager:	Sri Kusuma Hartani
Midterm Evaluator:	
Final Evaluator:	Kathy Tilford
Headquarter Financial Contact:	Prakash Basyal
Project Dates:	10/1/2010 - 10/1/2014 (FY2010)
Project Type:	Innovation
USAID Mission Contact:	Mildred Pantouw
Project Web Site:	http://www.mercycorps.org/tags/hati-kami

Field Program Manager

Name:	Sri Kusuma Hartani (Program Manager)
Address:	Graha STK F-Floor F-01 Suite Jl. Taman Margasatwa No.3, Ragunan South Jakarta , DKI Jakarta 12550 Indonesia
Phone:	+622178842686
Fax:	+622178842786
E-mail:	shartani@id.mercycorps.org
Skype Name:	kusuma.hartani

Alternate Field Contact

Name:	Danielle De Knocke Van Der Meulen (Director of Programs)
Address:	Graha STK F-Floor F-01 Suite Jl. Taman Margasatwa No.3, Ragunan South Jakarta , DKI Jakarta 12550 Indonesia
Phone:	+622178842686
Fax:	+622178842786
E-mail:	ddknockevdm@id.mercycorps.org
Skype Name:	

Grant Funding Information

USAID Funding: $1,458,953

PVO Match: $495,556

General Project Description

Mercy Corps, a 2010 Innovation category grantee, is implementing the *Hati Kami Child Survival Project*, which targets poor urban areas, in eight sub-districts of two municipalities of West Jakarta, Indonesia. The project goal is to build a replicable, cost-effective model to improve the continuum of care for mothers, newborns, and infants among Jakarta's poor residents. Mercy Corps will work to increase the utilization and quality of critical maternal and newborn care (MNC) health and nutrition services in public and private health facilities, improve MNC health practices at individual and household level, and improve collection, quality and utilization of MNC data.

Project Location

Latitude: -6.21	**Longitude:** 106.85
Project Location Types:	Urban
Levels of Intervention:	District Hospital Health Center Health Post Level Home Community
Province(s):	Jakarta
District(s):	Cengkareng and Kalideres
Sub-District(s):	Cengkareng Barat, Cengkareng Timur, Kapuk, Kedaung Kali Angke, Duri Kosambi, Rawa Buaya, Kamal, and Tegal Alur

Operations Research Information

OR Project Title:	Mobile-strengthened Monitoring and Tracking of Maternal and Child Health Data(mPWS)
Cost of OR Activities:	$199,945
Research Partner(s):	Center of Family Welfare Research, Faculty of Public Health, University of Indonesia
OR Project Description:	The government of Indonesia has recognized the value of using evidence-based data to accelerate progress towards the reduction of the country's high maternal and infant mortality rates. In 2007, the MOH (with support from UNICEF) developed the Local Area Monitoring and Tracking (LAMAT) system to provide comparable data across municipalities, districts, facilities (public & private), and communities to monitor performance (i.e. access and coverage) of immunization and MCH services. Data from the system provides opportunities to share best practices based on evidence and is used to help health program managers identify low-performing areas, and allocate/advocate resources based on need. However, there have been a number of operational bottle-necks within the system at the data collection, analysis, and dissemination levels that have discouraged many stakeholders including the private health providers from reporting or using the LAMAT data. To help address these challenges, Mercy Corps, in collaboration with Center of Family Welfare Research of the University of Indonesia *(CFW-UI)*, is introducing and assessing the effectiveness of using mobile technology to improve collection and use of quality data to inform local planning and resource allocation for better MCH interventions and outcomes.

Partners

Centre of Family Welfare Research (Pusat Penelitian Keluarga Sejahtera), Faculty of Public Health, University of Indonesia(Subgrantee)	$65,000
Provincial Health Office of Jakarta (Collaborating Partner)	$0
Ikatan Bidan Indonesia (IBI- Indonesian Midwive Association) - DKI Jakarta Branch(Collaborating Partner)	$0
Pemberdayaan Kesejahteraan Keluarga (PKK - Family Welfare Empowerment Organization) - all levels in Jakarta Province and West Jakarta Municipality (Collaborating Partner)	$0
Municipal Health Office of West Jakarta (Collaborating Partner)	$0
Public Health Centers in 8 target sub districts in West Jakarta (Collaborating Partner)	$0
Health[e]Foundation (international) (Subgrantee)	$14,000

Strategies

Social and Behavioral Change Strategies:	Community Mobilization Group interventions Interpersonal Communication Social Marketing
Health Services Access Strategies:	Addressing social barriers (i.e. gender, socio-cultural, etc) Implementation with a sub-population that the government has identified as poor and underserved Implementation in a geographic area that the government has identified as poor and underserved
Health Systems Strengthening:	Quality Assurance Supportive Supervision Developing/Helping to develop clinical protocols, procedures, case management guidelines Developing/Helping to develop job aids Monitoring health facility worker adherence with evidence-based guidelines Providing feedback on health worker performance Monitoring CHW adherence with evidence-based guidelines Community role in recruitment of CHWs Coordinating existing HMIS with community level data Community input on quality improvement
Strategies for Enabling Environment:	Advocacy for revisions to national guidelines/protocols Stakeholder engagement and policy dialogue (local/state or national) Advocacy for policy change or resource mobilization Building capacity of communities/CBOs to advocate to leaders for health
Tools/Methodologies:	Rapid Health Facility Assessment Community-based Monitoring of Vital Events LQAS Mobile Devices for Data Collection

Capacity Building

Local Partners:	Local Non-Government Organization (NGO) National Ministry of Health (MOH) Dist. Health System Health Facility Staff Other National Ministry Health CBOs Other CBOs Non-government sanctioned CHWs Private Providers (Other Non-TBA) Faith-Based Organizations (FBOs)

Interventions & Components

Control of Diarrheal Diseases (10%) - Hand Washing - Feeding/Breastfeeding	CHW Training HF Training
Infant & Young Child Feeding (50%) - ENA - Comp. Feed. from 6 mos. - Cont. BF up to 24 mos. - Growth Monitoring - Maternal Nutrition - Peer support - Promote Excl. BF to 6 Months - Support baby friendly hospital	CHW Training HF Training
Maternal & Newborn Care (40%) - Recognition of Danger signs - Newborn Care - Integation. with Iron & Folic Acid - Normal Delivery Care - Kangaroo Mother Care (skin to skin care)	CHW Training HF Training

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health			
Gender	**Year**	**Target**	**Actual**
Female	2010		
Female	2010		0
Male	2010		0
Male	2010		
Female	2011	53	
Female	2011		250
Male	2011		0
Male	2011	9	
Female	2012	2270	
Female	2012		1337
Male	2012		40
Male	2012	1690	
Female	2013	2000	
Female	2013		2222
Male	2013		299
Male	2013	250	
Female	2014	200	
Female	2014		446
Male	2014		260
Male	2014	50	
Number of People Trained in Child Health & Nutrition			
Gender	**Year**	**Target**	**Actual**
Female	2010		
Female	2010		0
Male	2010		0
Male	2010		
Female	2011	53	
Female	2011		250
Male	2011		0
Male	2011	2	
Female	2012	2500	
Female	2012		1337
Male	2012		40
Male	2012	1690	
Female	2013	2000	
Female	2013		2222
Male	2013		299
Male	2013	250	
Female	2014	200	
Female	2014		446
Male	2014		260
Male	2014	50	
Number of People Trained in Malaria Treatment or Prevention			
Gender	**Year**	**Target**	**Actual**
Female	2010		0
Female	2010		
Male	2010		0
Male	2010		
Female	2011		0
Female	2011	0	
Male	2011		0

Male	2011	0	
Female	2012		0
Female	2012	0	
Male	2012		0
Male	2012	0	
Female	2013		0
Female	2013	0	
Male	2013		0
Male	2013	0	
Female	2014		0
Female	2014	0	
Male	2014		0
Male	2014	0	

Locations & Sub-Areas

Total Population: 687,407

Target Beneficiaries

	Indonesia - MC - FY2010
Children 0-59 months	64,100
Women 15-49 years	131,211
Beneficiaries Total	195,311

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**26**	**300**	**8.7%**	**4.5**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**296**	**300**	**98.7%**	**1.8**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**18**	**137**	**13.1%**	**8.0**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**106**	**168**	**63.1%**	**10.3**
Percentage of children age 12-23 months who received a measles vaccination	**75**	**85**	**88.2%**	**9.7**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**47**	**85**	**55.3%**	**14.9**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**37**	**85**	**43.5%**	**14.9**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	**16**	**47**	**34.0%**	**19.2**
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	**24**	**27**	**88.9%**	**16.8**
Percentage of households of children age 0-23 months that treat water effectively	**165**	**300**	**55.0%**	**8.0**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**52**	**300**	**17.3%**	**6.1**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**0**	**0**	**0.0%**	**0.0**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**27**	**257**	**10.5%**	**5.3**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**59**	**168**	**35.1%**	**10.2**
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	**274**	**300**	**91.3%**	**4.5**
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	**204**	**300**	**68.0%**	**7.5**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	**178**	**300**	**59.3%**	**7.9**

Rapid Catch Indicators: Mid-term

Sample Type: LQAS

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**263**	**266**	**98.9%**	**1.3**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**48**	**93**	**51.6%**	**10.2**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who received a measles vaccination	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**57**	**91**	**62.6%**	**9.9**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	**13**	**76**	**17.1%**	**8.5**
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	**0**	**0**	**0.0%**	**0.0**
Percentage of households of children age 0-23 months that treat water effectively	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**88**	**266**	**33.1%**	**5.7**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**0**	**0**	**0.0%**	**0.0**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**0**	**0**	**0.0%**	**0.0**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**169**	**173**	**97.7%**	**2.2**
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	**265**	**266**	**99.6%**	**0.7**
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	**237**	**266**	**89.1%**	**3.7**

Rapid Catch Indicators: Final Evaluation

Sample Type: 30 Cluster

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**221**	**330**	**67.0%**	**7.2**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**329**	**330**	**99.7%**	**0.8**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**61**	**143**	**42.7%**	**11.5**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**109**	**187**	**58.3%**	**10.0**
Percentage of children age 12-23 months who received a measles vaccination	**90**	**99**	**90.9%**	**8.0**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**59**	**99**	**59.6%**	**13.7**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**60**	**99**	**60.6%**	**13.6**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	**11**	**15**	**73.3%**	**31.6**
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	**56**	**98**	**57.1%**	**13.9**
Percentage of households of children age 0-23 months that treat water effectively	**210**	**330**	**63.6%**	**7.3**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**77**	**330**	**23.3%**	**6.5**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**46**	**330**	**13.9%**	**5.3**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**50**	**187**	**26.7%**	**9.0**
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	**277**	**330**	**83.9%**	**5.6**
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	**238**	**330**	**72.1%**	**6.8**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	**242**	**330**	**73.3%**	**6.7**

Rapid Catch Indicator Comments

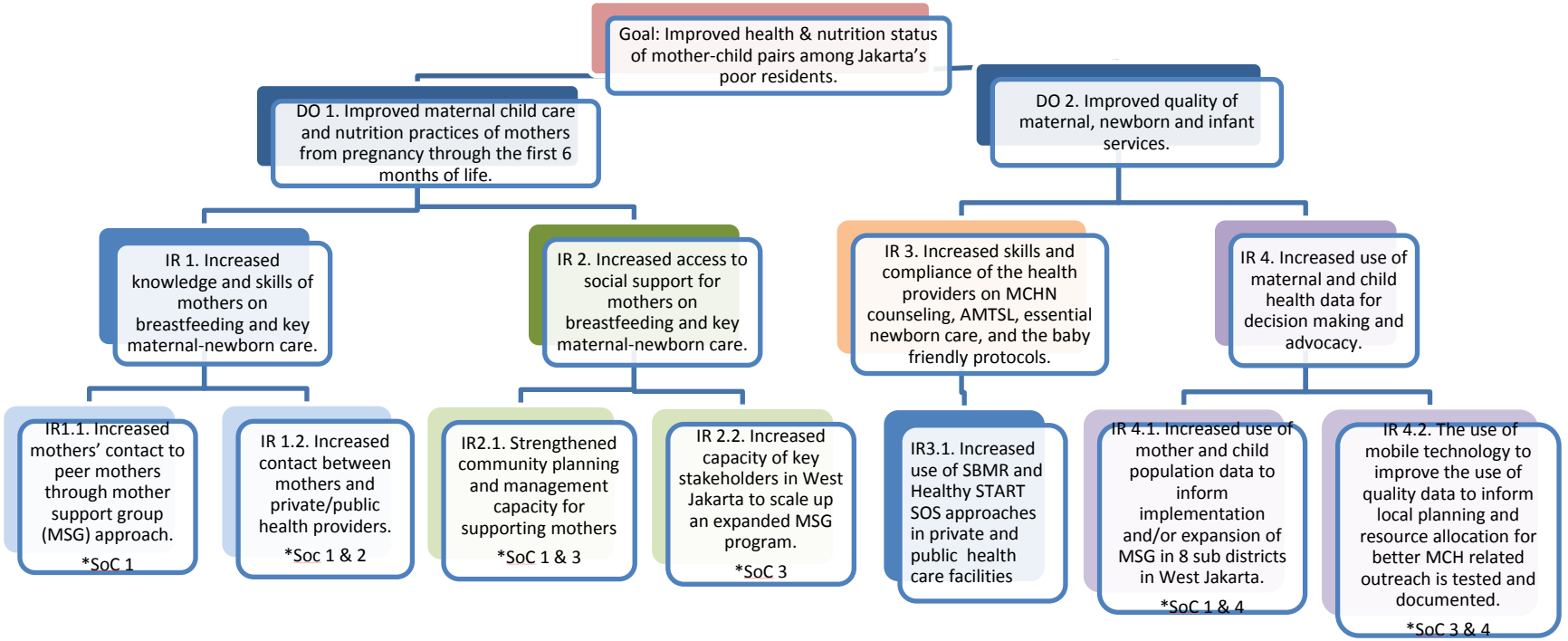
Malaria related indicators are not collected because the program area is not a malaria endemic zone.

Although program performance is not measured against the use of ORS in diarhea treatment , it is a sensitive indicator in that children age under 2 years old in Jakarta are vulnerable to dehydration, which can be a fatal complication.

ANNEX XIX – A. Complete Results Framework

Sphere of Control (SoC):

1. Strategies to engage community structures and partners, and advance social capital
2. Strategies to ensure delivery of quality and equitable community level services, with CQI
3. Strategies to promote institutionalization of community level MNCH services in the formal and informal health systems
4. M&E systems and learning platforms to enable evidence-based decision making



Strategies/Activities
- Replicate new expanded MSG model
- Integrate counseling on maternal-infant health and nutrition in to the 7 contacts+ in maternal-newborn care

Strategies/Activities
- Implement contextualized and targeted communication strategy

Strategies/Activities
- Adopt and replicate SBMR and baby friendly protocols
- Support MHO and IBI in training providers on Kangaroo mother care

Strategies/Activities
- Test and document use of mobile technology to inform local planning
- Support sub-district level quarterly MCH problem solving discussions at the community level

ANNEX XIX - B. RESULTS FOR 13 KEY PROGRAM INDICATORS

Strategic Objective 1: Improved maternal child care and nutrition practices of mothers from pregnancy through the first 6 months of life													
No	**Outcome Indicator**	**Definition**	**Revised/ Baseline Value**	**95% CI**	**Lower**	**Upper**	**EOP Target Value**	**Endline Value**	**95% CI**	**Lower**	**Upper**	**t**	**p**
1	**Timely Initiation of Breastfeeding**	Numerator: Number of children 0-23 months who were put on the breast within 1 hour after delivery	62.3%	7.8%	54.6%	70.1%	72.0%	64.8%	7.3%	57.6%	72.1%	-0.46	0.645
	% children 0-23 months who were put on the breast within 1 hour after delivery	Denominator: Total number of mothers of children age 0-23 months in the survey.											
2	**Early Initiation of Breastfeeding**	Numerator: Number of children age 0-23 months who were put on the mother's breast or tummy's skin right after birth AND was left there for at least 1 hour OR until it stopped suckling	23.3%	6.8%	16.6%	30.1%	33.0%	40.6%	7.5%	33.1%	48.1%	-3.35	0.001
	% children 0-23 months who were put on the mother's breast or tummy's skin right after birth for at least 1 hour or until it stopped suckling	Denominator: Total number of mothers of children age 0-23 months in the survey.											
3	**Exclusive breastfeeding**	Numerator: Number of children age 0-5 months who received only breast-milk during the last 24 hours AND Did not drink any other liquids during the last 24 hours AND was not given any other foods or liquids during the last 24 hours.	23.4%	10.0%	13.3%	33.4%	38.0%	42.7%	11.5%	31.2%	54.1%	-2.48	0.016
	% children 0-5 months who were exclusively breastfed during the last 24 hours	Denominator: Total number of mothers of children age 0-5 months in the survey.											
4	**No pre-lacteal feeds**	Numerator: Number of children age 0-23 months who was ever breastfed AND **did not** receive any food or liquid other than breast milk within the first 3 days after delivery	47.0%	8.0%	39.0%	55.0%	55.0%	76.4%	6.5%	69.9%	82.8%	-5.59	0.000
	% children age 0-23 months **who did not** receive pre-lacteal feeds.	Denominator: Total number of mothers of children age 0-23 months in the survey.											
5	**Having more carbohydrate in pregnancy**	Numerator: Number of pregnant women reporting an increased meal or portion of staple food during pregnancy.	23.7%	4.2%	19.5%	27.9%	25.0%	64.9%	5.5%	59.4%	70.4%	-11.61	0.000
	% pregnant women who reported having increased portion of staple food during pregnancy	Denominator: Total number of pregnant women in the survey											
6	**Iron supplement in pregnancy**	Numerator: Number of pregnant women who reported having taken one iron tablet/syrup/supplement one day before the survey.	56.4%	4.9%	51.5%	61.3%	60.0%	67.3%	5.4%	61.9%	72.7%	-2.92	0.005
	% pregnant women who reported taking an iron supplement yesterday	Denominator: Total number of pregnant women in the survey											
7	**Folic acid supplement in pregnancy**	Numerator: Number of pregnant women reported having taken one folic acid tablet/syrup/supplement one day before the survey.	62.1%	4.8%	57.2%	66.9%	65.0%	81.4%	4.5%	76.9%	85.9%	-5.75	0.000
	% pregnant women who reported taking folic acid tablet yesterday	Denominator: Total number of pregnant women in the survey											

Strategic Objective 2: Improved quality of maternal, newborn and infant services													
No	**Outcome Indicator**	**Definition**	**Revised/ Baseline Value**	**95% CI**	**Lower**	**Upper**	**Updated EOP Target Value**	**Endline Value**	**95% CI**	**Lower**	**Upper**	**t**	**p**
1	**Quality antenatal care (ANC)**	Numerator: average score of health service providers assessed with SBMR standard for Antenatal care	87.0%	n/a	n/a	n/a	89.0%	92.4%	n/a	n/a	n/a	n/a	n/a
	% health service providers' compliance in giving standard antenatal care	Denominator: Total score for standard antenatal care in SBMR checklist											
2	**Compliance to standard Post-Partum and Post-Natal care**	Numerator: average score of health service providers assessed with SBMR standard for Post-Partum and Post-natal care	92.5%	n/a	n/a	n/a	94.0%	98.3%	n/a	n/a	n/a	n/a	n/a
	% health service providers' compliance in giving standard Post-Partum and Post-Natal care	Denominator: Total score for standard Post-partum and Post-Natal care in SBMR checklist											
3	**Compliance to standard Normal delivery and Newborn care**	Numerator: average score of health service providers assessed with SBMR standard for Normal Delivery and Newborn care	88.0%	n/a	n/a	n/a	90.0%	96.8%	n/a	n/a	n/a	n/a	n/a
	% health service providers' compliance in giving standard Normal delivery and Newborn care	Denominator: Total score for standard Normal delivery and Newborn care in SBMR checklist											
4	**Active Management of the third stage of labor (AMTSL)**	Number of mothers of children age 0-23 months who immediately after the birth of their youngest child received an injection of uterotonic drug AND Controlled cord traction was performed AND Received uterine massage after the delivery of the placenta	30.0%	7.3%	22.7%	37.3%	35.0%	43.6%	7.6%	36.1%	51.2%	-5.59	0.00
	% mothers of children age 0-23 months who received AMTSL after the birth of her youngest child.	Denominator: Total number of mothers of children age 0-23 months in the survey.											
5*	**Counseling access for mothers**	Numerator: Mothers of children 0-23 months who reported having had health providers speak to her about breastfeeding OR maternal care OR infant care	40.0%	7.8%	32.2%	26.4%	50.0%	79.7%	6.1%	73.6%	85.8%	-7.81	0.00
	% mothers of children age 0-23 months who received counseling on breastfeeding or maternal and infant care messages	Denominator: Total number of mothers of children age 0-23 months in the survey.											
6*	**Counseling access in pregnancy**	Numerator: Pregnant women who reported having had health providers speak to her about breastfeeding OR maternal care OR infant care	71.5%	4.5%	67.1%	76.0%	81.5%	58.1%	5.7%	52.4%	63.8%	3.64	0.0006
	% pregnant women who received counseling on breastfeeding or key maternal and infant care messages	Denominator: Total number of pregnant women in the survey											

Baseline values, endline values and targets for Indicators 5* and 6* were recalculated during the Final Evaluation.

ANNEX XIX – C. Materials Developed By and For Religious Leaders

Introduction:

The principal Indonesian development goal is to have a developed, independent, prosperous – both physically and mentally-- nation. One of the characteristic of a developed nation is to have a high level of health because good health has a significant impact on the quality of human resources. A healthy population is expected to be the main factor to increase productivity and the nation's competitiveness in the future.

In recognition to this, the Government of the Republic of Indonesia articulated a set of policies and strategies through the Millennium Development Goals (MDGs), especially Goals 4 and 5 which are to reduce the child mortality rate and improve maternal health by 2015.

Men and women religious leaders play an important role in guiding communities and promoting improved maternal and child health levels in their neighborhoods. Information and messages are easier to for people to accept when they come from respected religious leaders. In recognition of the importance of religious leaders' role in promoting good health, Mercy Corps in partnership with the Indonesian Ulema Council of West Jakarta, PKK West Jakarta, the Municipality Health Office of West Jakarta, and IBI West Jakarta facilitated the development of this "Maternal and Child Health from Islam' s Perspective" book.

This book aims to provide references and materials for religious leaders when giving talk during religious gatherings and Friday prayer in their areas. This book is published in three different formats: main book, pocket book (booklet), and brochures. This book consists of seven main topics: (1) Happy Family, Healthy Family; (2) Steps of Human Creation inside the Womb; (3) Healthy Pregnancy Care; (4) Beware of Pregnancy Scare; (5) Children are Gifts from God; (6) Breast Milk is the First Food from God; and (7) Role of Head of Family

With the creation of this book, it is hoped that religious leaders can play an important role in improving maternal and child health in West Jakarta.

A. MATERNAL AND CHILD HEALTH BOOK

Table of Contents:

Role of Head of Family

Constituent Team:

Indonesian Ulema Council (MUI) West Jakarta

PKK West Jakarta

Municipality Health Office West Jakarta

Indonesian Midwives Association (IBI) West Jakarta

Mercy Corps Indonesia

B. MATERNAL AND CHILD HEALTH POCKET BOOK (BOOKLET)

Table of Contents:

Foreword

Introduction

Happy Family, Healthy Family

Steps of Human Creation inside the Womb

Healthy Pregnancy Care

Beware of Pregnancy Scare

Children are Gifts from God

Breast Milk is the First Food from God

Role of Head of Family

C. MATERNAL AND CHILD HEALTH BROCHURES

(1) Happy Family, Healthy Family

(2) Steps of Human Creation inside the Womb

(3) Healthy Pregnancy Care

(4) Beware of Pregnancy Scare

(5) Children are Gifts from God

(6) Breast Milk is the First Food from God

(7) Role of Head of Family; and

(8) The Beauty of Adzan (prayer call) When We Breastfeed Our Child for the First Time